Responses to supplemental request for additional materials and information relating to the July 14-15 hearings on *medical malpractice* before the Senate Committee on Judiciary

THE FLORIDA SENATE
COMMITTEE ON JUDICIARY

Location
515 Knott Building
Mailing Address
404 South Monroe Street
Tallahassee, Florida 32399-1100
(850) 487-5180
J. Alex Villalobos, Chair
Dave Aronberg, Vice Chair
Dave Roberts, Staff Director
Senate's Website: www.flsenate.gov

July 29, 2003

Elizabeth Dudek
Deputy Secretary, Division of Health Quality Assurance
Agency for Health Care Administration
2727 Mahan Dr.
Tallahassee, FL 32308

Dear Ms. Dudek:

In reviewing the transcript of the Senate Committee on Judiciary meeting on July 14-15, 2003, we have identified several occurrences where you were asked to provide information subsequent to your testimony. Additionally, the committee has identified certain issues for which it requests additional information. Specifically, we request a response in the following instances:

1. How many Florida licensed facilities provide obstetrical services? How many facilities have ceased to provide obstetrical delivery services? For those facilities that no longer provide delivery services, what was the reason stated for ceasing to provide that service? Please provide the committee with copies of the records describing the reasons for ceasing to provide these services.
2. How many Florida licensed facilities have stopped offering high-risk procedures? How is a procedure classified as a high-risk procedure? How does AHCA know if a facility ceases to provider certain procedures?
3. How many Florida emergency rooms have closed or reduced services? If services have been reduced in an emergency room, what services have been reduced? Please provide copies of those records describing such changes in emergency room services.
4. How does Florida compare to other states with similar demographics with regard to the availability of emergency room services?
5. Please provide a report indicating the expansion of hospital facilities or related facilities such as outpatient surgery centers and including the number of new hospital beds, in Florida for each of the last three years.

We ask that you please provide the appropriate responsive documentation to the Senate Committee on Judiciary no later than 5:00 pm on Monday, August 4, 2003. We recognize that you have already provided some information to the committee that may answer these questions. If this is the case, please indicate so in your response. To aid you in your response, we have attached those pages of the transcript that contain your testimony. If you have any questions, please contact Judiciary Committee staff at (850) 487-5180.

Sincerely,

Senator Alex Villalobos
Chair

JAMES E. "JIM" KING, JR.
President

ALEX DIAZ DE LA PORTILLA
President Pro Tempore

NC & HQ/HEADQUARTERS Fax:850-487-6240 Aug 1 2003 12:07 P.01

AHCA

JEB BUSH, GOVERNOR

FRANDA H. MEDOWS, MD, FAAFP, SECRETARY

August 1, 2003

The Honorable Alex Villalobos, Chair
Florida Senate Committee on Judiciary
404 South Monroe Street
Tallahassee, Florida 32399-1100

Dear Senator Villalobos:

Elizabeth Dudek, Deputy Secretary, Division of Health Quality Assurance will be out of the office and out of Tallahassee until August 12, 2003. Pursuant to Mike Pandav' conversation with David Greenbaum, since Ms. Dudek is currently unavailable to expand upon her testimony before the Senate Committee on Judiciary, please accept this request for an extension until August 15, 2003 for the response to your letter of July 29, 2003. We will appreciate your consideration of this request.

Sincerely,

Rebecca Kapp
Rebecca Kapp, Assistant Deputy Secretary
Division of Health Quality Assurance

cc: Dr. Rhonda Medows, Secretary, Agency for Health Care Administration
Jeffrey Gregg, Chief, Bureau of Health Facility Regulation
Michael Pandav, Legislative Affairs

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Tallahassee, FL 32308

Visit AHCA online at
www.fdhc.state.fl.us

Supplemental Addendum: *Agency for Health Care Administration's* Response to Supplemental Request for Additional Materials Regarding Medical Malpractice Committee Hearings on **JULY** 14 -15, 2003

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

JEB BUSH, GOVERNOR — RHONDA M. MEDOWS, MD, FAAFP, SECRETARY

August 14, 2003

The Honorable J. Alex Villalobos
Chair, Senate Committee on Judiciary
515 Knott Building
404 South Monroe Street
Tallahassee, FL 32399-1100

Dear Senator Villalobos:

Thank you for the opportunity to address the Senate Committee on Judiciary's additional questions and extending the time in which to respond due to my being on vacation. Please find below responses to the Committee's July 29, 2003 questions.

1. How many Florida licensed facilities provide obstetrical services? How many facilities have ceased to provide obstetrical delivery services? For those facilities that no longer provide delivery services, what was the reason stated for ceasing to provide that service? Please provide the committee with copies of the records describing the reasons for ceasing to provide these services.

   A review of our licensure files shows that 137 of Florida's 179 licensed general acute care hospitals provide obstetrical services. The state also has 21 licensed birthing centers. Staff have reviewed both Certificate of Need and individual licensure files and found that eight hospitals have reported discontinuation of obstetrical services since 1999, including Largo Medical Center and St Anthony's Hospital, both of Pinellas County; Doctors Hospital of Sarasota; Charlotte Regional Medical Center in Charlotte County; Oak Hill Community Hospital in Hernando County; Health South Doctors Hospital and Aventura Hospital of Miami-Dade County; and Florida Hospital-Kissimmee. Specific reasons for the discontinuation of a service are not required and they are not typically given in correspondence with the Agency; however, any available supporting paperwork related to the discontinuation of obstetrical services in the above hospitals is included as Attachment A. AHCA licensure printouts of the general acute care hospitals that do and do not offer obstetrical services are also included.

2. How many Florida licensed facilities have stopped offering high-risk procedures? How is a procedure classified as a high-risk procedure? How does AHCA know if a facility ceases to provide certain procedures?

   The Agency does not know how many Florida-licensed facilities have stopped offering high-risk procedures. There is no standard classification system for the term "high risk procedure." In addition to an assessment of risk associated with a particular procedure, a

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procedure may be classified as high risk depending on factors such as the patient's age or physical condition.

AHCA does not collect information about outpatient procedures delivered in the state's health care facilities other than ambulatory surgery provided by hospitals and licensed surgical centers; nor does the Agency collect data on emergency room procedures. The Agency currently has an administrative rule under development that would require hospitals to begin reporting information about emergency room procedures.

AHCA's information about specific procedures is limited to hospital inpatient procedures, although there is generally a six to twelve month lag time before it is published. The Agency would not know if a facility ceases to offer a certain inpatient procedure until, at a minimum, after the six to twelve month lag time associated with data collection.

I have been told that the Agency has been advised that physicians are refusing to perform procedures that they have traditionally performed, and indicating that the reason they have done so is the risk associated with particular procedures. For example, we have heard reports of OB-GYN specialists who continue to perform gynecological surgery while discontinuing the delivery of babies. We are also concerned about qualified physicians in community hospitals referring difficult, high-risk patients to regional safety net providers where the staff has sovereign immunity. This presents a particular quality concern due to unnecessary delays in patient care.

3. How many Florida emergency rooms have closed or reduced services? If services have been reduced in an emergency room, what services have been reduced? Please provide copies of those records describing such changes in emergency room services.

   The Agency is not aware of any emergency rooms in the state's hospitals that have closed. Typically, an emergency room closes because it is located in a hospital that closes. A list of Florida hospital closures since 1996 is included as Attachment B.

   Hospitals are not required to have emergency rooms but are required to offer emergency services that mirror their inpatient services. Specifically, s. 59A-3.252(2), F.A.C., states that "In addition to other requirements specified in these rules, all licensed hospitals shall have at least the following..." 59A-3.252(2)(h) "A procedure for providing care in emergency cases." In this case, a "procedure" could be defined simply as a mechanism for transfer.

   Nine hospitals have requested Agency waivers in order to be allowed to reduce services in their emergency departments. These waivers allow a hospital not to offer a service in its emergency room that it offers on an inpatient basis. The nine hospitals have requested waivers for 11 different medical specialties, and supporting documentation is included in Attachment B. Other hospitals may have discontinued certain services but failed to request a waiver. The Agency is not likely to know about any such situation unless we investigate a complaint that exposes the hospital's failure to request a waiver in order to cut back or eliminate certain emergency services.

4. How does Florida compare to other states with similar demographics with regard to the availability of emergency room services?

   The Agency is not aware of a systematic study of emergency room closures in different states. There is no way to compare states without a detailed, time-consuming study.

5. Please provide a report indicating the expansion of hospital facilities or related facilities such as outpatient surgery centers and including the number of new hospital beds, in Florida for each of the last three years.

   Attachment C includes a report from the Certificate of Need (CON) program related to Florida hospital bed expansions in recent years.

Thank you again for being asked to provide information on the part of the Agency. If I can be of any further assistance, or if clarification is needed, I can be contacted at 850-414-9796.

Sincerely,

Elizabeth Dudek, Deputy Secretary
Division of Health Quality Assurance

ATTACHMENT A

delete

Doctors Hospital of Sarasota to close obstetrics unit Dec. 1

BY MARGARET ANN MILLE

SARASOTA -- Doctors Hospital of Sarasota is closing its obstetrics department Dec. 1 in the face of escalating medical malpractice insurance.

The 168-bed hospital will continue to deliver babies until Nov. 15. After that, Sarasota Memorial Hospital will be the closest alternative.

"We just don't make any money on the OB," said Lindell Orr, Doctors' chief executive. "In order to keep one open, you have to at least break even."

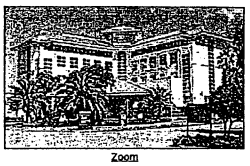
Closing the department will save the hospital about $1 million annually, he said. The closing was approved by the hospital board late Wednesday and by its medical executive committee last week.

"Obviously, I'm disappointed," said Joseph Corcoran, an OB-GYN and an executive committee member. "It was not a popular decision, yet it was a decision that everyone knew had to be made."

The HCA-owned hospital paid nearly $1.62 million this year in malpractice premiums, 32 percent more than the previous year, said Orr.

About $500,000 of that went for its obstetrics unit. Orr estimated that if Doctors Hospital continued to deliver babies, overall liability insurance could rise as high as $2.5 million next year.

And, insurance aside, obstetrics is a losing proposition at Doctors, where about 800 babies are born each year. The department takes in more than $5 million a year but ends up $500,000 in the red, partly because of declining managed care reimbursements and the high cost of equipment.



Zoom

FILE PHOTO
Doctors Hospital of Sarasota is closing its obstetrics department.

Orr said the decision to close wasn't made lightly.

"It's extremely hard," he said. "Everybody is kind of up in the air with this liability situation."

While liability premiums vary widely by specialty and geography, they generally are highest nationwide for obstetrics-gynecology, neurosurgery and cardiovascular surgery because of the high risk that problems could occur.

At Fawcett Memorial Hospital, an HCA hospital in Port Charlotte, the medical staff has voted to change the bylaws so they can individually drop insurance. The board of trustees has approved the change and recommended it to the hospital's parent company.

HCA agreed so long as the doctors secure a letter of credit or an escrow account for the minimum amount required under Florida law.

Fawcett doesn't have an obstetrics department. Neither does HCA's Englewood Community Hospital.

After Nov. 15, Blake Medical Center, a 383-bed sister hospital in Bradenton, will be the only HCA hospital in Sarasota and Manatee counties to deliver babies.

Blake spokeswoman Ginger Mace said she doesn't expect that to change.

The same goes for Sarasota Memorial, a public 845-bed hospital. Sarasota Memorial won't drop obstetrics, despite the fact that the unit lost $3 million in the last fiscal year, said John Yoder, SMH's chief operating officer.

"That's because we are a public community-owned hospital," Yoder said. "It's our mission to provide full service to the community."

Sarasota Memorial, where managers expect 2,169 newborns to be delivered this fiscal year, can handle the extra 800 births that the closing at Doctors will generate, Yoder said.

Both Yoder and Orr said the closing could reduce the running back and forth between hospitals for physicians on staff, most of whom have privileges at both Doctors and Sarasota Memorial.

Many of those physicians don't have privileges at Bradenton's Manatee Memorial Hospital, which is building a hospital campus at Lakewood Ranch that could be an alternative to Sarasota Memorial.

Groundbreaking on that 120-bed hospital is scheduled in October with completion expected in January 2004.

Doctors Hospital has notified its physicians, staff and expectant mothers of plans to close the obstetrics department.

The end of the program will affect about 36 nurses, 20 of whom work there full time. Nursing chief Linda Lemon-Steiner said the nurses will be given the option of transferring to another department within Doctors or to an HCA hospital that has obstetrics.

It's a difficult decision for Linda Button, a nurse who helped start the hospital's family-centered birthing care program eight years ago.

"It's a very emotional day for all of us," said Button, who might work a few months in Miami as a "traveler nurse" while she sorts out her next move. She would like to stay at Doctors, but feels compelled to work in labor and delivery.

She will stay put at least until Nov. 15, the last day Doctors will deliver babies.

"I helped catch the first baby," Button said. "They promised me I'm going to be able to catch the last one."

Last modified: August 30. 2002 7:24AM

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GOVERNMENTAL CONSULTANTS
MARGARET A. MENDUNI
M. LANE STEPHENS

September 17, 2002

Via Hand Delivery
Pat Underwood
Agency for Health Care Administration
Hospital and Outpatient Services Unit
2727 Mahan Drive, Building 1
Tallahassee, Florida 32308

Re: Largo Medical Center/Closure of Obstetrical Services

Dear Ms. Underwood:

This firm is the authorized representative of Largo Medical Center ("Largo"). The purpose of this letter is to advise you that Largo intends to discontinue obstetrical services at the hospital effective December, 2002. It is my understanding from our conversation of September 4, 2002 that the Agency for Health Care Administration requires no further notice pertaining to the closure of obstetrical services at Largo.

Thank you for your attention to this matter. Please contact me immediately if you should have a different understanding or need additional information.

Sincerely,

Thomas W. Konrad

TWK/tls

Entered into FRAES 9-18-02

St.Petersburg Times ONLINE TAMPA BAY

Baby Place to close its doors Dec. 1

Largo Medical Center's maternity ward is closing because of rising insurance costs for obstetricians.

By MICHAEL SANDLER, Times Staff Writer

Largo Medical Center's maternity ward is closing because of rising insurance costs for obstetricians.

LARGO -- Lullabies are broadcast over the loudspeakers whenever a baby is born at Largo Medical Center. But soon those melodies will cease, as the hospital plans to stop delivering babies by the end of this year.

The Baby Place, a name staff and expectant mothers have used for the hospital's obstetrical services program, will be closed Dec. 1.

Thomas Herron, president and CEO of Largo Medical Center, said the decision was directly related to the rising cost of medical malpractice insurance and to insurers leaving the state.

He said the staff recently lost two obstetricians because of the rise in insurance rates, and that has greatly affected the hospital's capacity to assist women with their deliveries.

"Those two doctors accounted for most of our deliveries," Herron said in a written statement. "As a result, our births have decreased almost 25 percent and we may also lose other obstetricians who have been put on notice their insurers are leaving the area."

The ward opened in January 1997, and the hospital delivered 602 babies that year. Last year that number reached 768 but quickly dropped this year with the departure of the obstetricians.

"This year, we don't expect to do any more than our first year," said Sandy Gourdine, the hospital spokesperson. "The number has gone done, especially in the last couple months."

Gourdine said the hospital made the announcement three months in advance so expectant mothers who planned on using Largo Medical Center can readjust their delivery location.

The hospital sent letters out this week notifying 86 expectant mothers, all of whom had scheduled deliveries there between now until the end of the year, of the changes.

Of those women, 10 are expecting after the ward closes and will need to make arrangements at one of six other area hospitals (see box).

Those expecting between now and Nov. 15 will be accommodated. Those expecting between Nov. 15 and Nov. 30 should consult their physician, Gourdine said, as due dates can vary.

"All of our services, all of our amenities, nothing will change until the program has changed on Dec. 1," Gourdine said.

"What we are telling moms and physicians: If your due date is Nov 15 or earlier, we will be here to deliver your baby as planned. We will actually continue to deliver until Nov. 30. But we are telling them if they have one past Nov 15, to talk with their physician."

The change is certain to affect area hospitals in the months ahead.

Bayfront Medical Center is one of the busiest for obstetricians. They delivered 3,209 babies last year and have delivered as many as 3,500 in past years.

A spokeswoman for the hospital said it would be happy to help accommodate those in need.

"We are not really sure how it will affect us," said spokeswoman Cassandra Morrell. "But one thing for sure is that we are ready, and we will do everything to ensure the continuity of care for those moms."

Gourdine said the Largo Medical Center does not anticipate laying off any of the 28 nursing employees who work in the Baby Place. With the current industry nursing shortage, transfers and reassignments are expected to assist them during the transition, she said.

Even though the hospital has a more renowned reputation for its cardiac services, Gourdine said newborns boosted spirits throughout the building.

"It's sad to think we won't hear lullabys after Dec. 1," Gourdine said. "It's a very difficult decision, but it's a necessary decision. It does not make our loss less. We love to have those lovely, sweet little babies coming through our hospital."

-- Michael Sandler can be reached at 445-4174 or sandler@sptimes.com.

Any questions?

If you have questions about the decision to end baby deliveries at Largo Medical Center, call 588-5577. If you need to make a change, the hospital recommends you make arrangements with one of the following area facilities that offer obstetrical care:

St. Petersburg General Hospital

Bayfront Medical Center

Mease Hospital Dunedin

Morton Plant Hospital

Community Hospital in New Port Richey

Helen Ellis Memorial Hospital

STATE OF FLORIDA
AHCA
AGENCY FOR HEALTH CARE ADMINISTRATION

JEB BUSH, GOVERNOR

RUBEN J. KING-SHAW, JR., DIRECTOR

September 30, 1999

Ms. Deborah S. Platz
Panza, Maurer, Maynard & Neel, P.A.
Attorneys and Counselors At Law
Nationsbank Building, Third Floor
3600 North Federal Highway
Fort Lauderdale, Florida 33308-6225

Re: Discontinuation of Services
Exemption #9900386
HealthSouth Doctors' Hospital
Dade County

Dear Ms. Platz:

Thank you for your September 24 letter requesting certificate of need for the discontinuation of obstetrical services. Your letter is being responded to as the authorized representative, as represented by your letter, to act on behalf of the license holder, HealthSouth Doctors' Hospital, Inc., for the facility of HealthSouth Doctors' Hospital. Specifically, you describe the proposed project as follows:

To discontinue obstetrical services at HealthSouth Doctor's Hospital.

Section 408.036(3)(l), *Florida Statutes*, eliminates certificate of need review for the termination of a health care service.

Therefore, based on the above information which was relied upon in making this determination, your proposed project is not subject to certificate of need review. However, the office of Plans & Construction must determine if the project is reviewable by that office before any construction is undertaken. Contact the office of Plans and Construction for information concerning the requirements for plan submittal or exemption from review.

If any elements of this project should change, please notify this office in order to ensure the project is still not subject to review. If I may be of further assistance, please let me know.

Sincerely,

Karen Rivera
Health Services & Facilities Consultant Supervisor
Certificate of Need & Financial Analysis

KR:kwb

cc: Health Council of South Florida, Inc.
Plans and Construction, Skip Gregory, Bob Garland
Health Facility Compliance, Hospital Section

2727 MAHAN DRIVE TALLAHASSEE, FL 32308

Client/Matter No: 9913263(ap)

PANZA, MAURER, MAYNARD & NEEL, P.A.
Attorneys and Counselors at Law
3600 North Federal Highway, Third Floor
Fort Lauderdale, Florida 33308

(954) 390-0100
FAX: (954) 390-7991

RECEIVED
SEP 24 1999
CON/BUDGET
REVIEW OFFICE

DATE: September 24, 1999

TO: Scott Hopes
Bureau Chief
Certificate of Need & Financial Analysis

COMPANY: Agency for Health Care Administration

Phone (850) 922-0791

Fax (850) 922-6964

FROM: Deborah S. Platz, Esquire
PANZA, MAURER, MAYNARD & NEEL, P.A.

NUMBER OF PAGES 17 (INCLUDING THIS COVER PAGE)

COMMENTS OR SPECIAL INSTRUCTIONS:

Please see attached.

IF THERE ARE ANY PROBLEMS OR COMPLICATIONS IN RECEIVING THIS FAX, PLEASE NOTIFY THIS OFFICE IMMEDIATELY AT (954) 390-0100. THANK YOU.

THE INFORMATION CONTAINED IN THIS FACSIMILE MESSAGE IS ATTORNEY PRIVILEGED AND CONFIDENTIAL INFORMATION INTENDED ONLY FOR THE USE OF THE INDIVIDUAL OR ENTITY NAMED ABOVE.

IF THE READER OF THIS MESSAGE IS NOT THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT ANY DISSEMINATION, DISTRIBUTION OR COPY OF THIS COMMUNICATION IS STRICTLY PROHIBITED. IF YOU HAVE RECEIVED THIS COMMUNICATION IN ERROR, PLEASE IMMEDIATELY NOTIFY US BY TELEPHONE, THANK YOU.

PANZA, MAURER, MAYNARD & NEEL, P.A.
ATTORNEYS AND COUNSELORS AT LAW
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PLEASE REPLY TO
FORT LAUDERDALE OFFICE

September 24, 1999

TALLAHASSEE OFFICE
215 SOUTH MONROE STREET
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(850) 681-0650
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MICHAEL R. VINES

Via Facsimile and U.S. Mail
Scott Hopes, Bureau Chief
Bureau of Certificate of Need & Financial Analysis
Agency for Health Care Administration
2727 Mahan Drive, Bldg. 3, Room 1221
Tallahassee, FL 32308

9900066

Re: Discontinuation of Obstetrical Services at HealthSouth Doctors' Hospital

Dear Mr. Hopes:

Enclosed please find the information requested by Elizabeth Dudek concerning HealthSouth Doctors' Hospital's intent to discontinue obstetrical services at its facility.

With respect to a copy of the Board Minutes authorizing termination of OB services, please be advised that no such document exists as it relates to the HealthSouth Doctors' Hospital facility itself. The decision to terminate OB services at Doctors' Hospital was made at the HealthSouth corporate level, and I am still in the process of trying to determine whether or not any documentation exists which memorializes HealthSouth Corp.'s decision to terminate OB services at HealthSouth Doctors' Hospital. Furthermore, no such documentation exists which specifically designate an authorized representative of the hospital to terminate the obstetrical services. Lincoln Mendez, as CEO of HealthSouth Doctors' Hospital, was responsible for notifying all of the interested parties of HealthSouth's decision to discontinue the OB services. As counsel for HealthSouth, our firm was notified by Lincoln Mendez of HealthSouth's decision whereby we, on behalf of HealthSouth, notified the Agency of the decision.

Finally, with respect to copies of policies and procedures for emergency room personnel for managing Walk-in, active labor patients, HealthSouth is currently updating its policies and procedures for its emergency room personnel for managing walk-in active labor patients and I will forward a copy to the Agency as soon as this document is finalized.

I am deeply sorry for any misunderstandings that our firm had with respect to notifying the Agency about HealthSouth's decision to discontinue obstetrical service at HealthSouth Doctors'

Hopes
September 24, 1999
Page 2

Hospital. I can assure you that HealthSouth is committed to providing the Agency with any and all information that is required and will work with the Agency to assure that this change in services does not affect the quality of care that HealthSouth is committed to providing.

Thank you for your assistance in this matter. If I can be of any additional service or answer any questions you may have, please do not hesitate to contact me.

Sincerely,

Deborah Platz
DEBORAH S. PLATZ

DSP/sp
Enclosure

P:\CLIENT\00053\9991\LETTER\HOPES.01

EALTHSOUTH
South Doctors' Hospital
University Drive • Coral Gables, FL 33146

Labor & Delivery / Obstetrical Services
Delicensure Information

Number of Deliveries at HealthSouth Doctors' Hospital Y.T.D.: 811 (January - August)
Please See Attached Documentation "Exhibit A"

Notification Letters *(Please See Attached Documentation) "Exhibit B"*
- Physicians on Staff
- OB / Gyn Physician Tenants
- Emergency Medical Services Providers
- Press Statement
- HealthSouth Doctors' Hospital Employees

Payor Mix for OB Services:

• Medicare Revenue	1%
• Medicaid Revenue	27% ✓
• B/C B/S Revenue	2%
• Managed Care Revenue	58% ✓
• Commercial Revenue	8%
• Other Revenue	6% ✓

Emergency Room Policies Regarding OB:
Currently being updated by Nursing Administration and the Emergency Room Department. Will provide copy of updated policies once available.

HealthSouth Doctors' Hospital
Obstetrical Services Statistics
1999

EXHIBIT 'A'

Total deliveries	108	93	104	93	97	105	85	116						
Total C/Section	34	22	29	25	21	23	26	32						
Primary	20	13	16	11	12	10	13	16						
Repeat	14	9	13	14	9	13	13	16						
Total VBACs	3	4	2	3	3	1	4	4						
C/Section rate (%)	32%	24%	27%	26%	21%	22%	27%	27%						
Repeat C/Section rate (%)	16%	11%	15%	17%	10%	13%	16%	16%						
C/Sections of 7#g or less	0	0	0	0	0	0	0	0						
VBAC rate (%)	4%	6%	3%	4%	3%	1%	5%	5%						
Unplanned admission	0	0	0	0	0	0	0	0						
Transfer to ICU	0	1	0	0	0	0	0	1						
Complications of OB procedures/	2	1	0	0	0	0	0	0						
interventions (i.e., nicked bladder														
or ruptured uterus)														
Maternal Deaths	0	0	0	0	0	0	0	0						
Fetal deaths (<500 grams)	1	1	1	1	1	0	1	1						
Stillbirths (>500 grams)	0	0	0	1	0	0	0	0						
Stillborns resulting in C/Sections	0	0	0	0	0	0	0	0						
Unattended deliveries	1	1	1	0	1	0	1	2						
Newborn complication	9	3	18	18	20	23	24	15						
Newborn transfer to other facilities	3	1	3	3	2	3	9	6						

Average: 101/month

EALTHSOUTH
South Doctors' Hospital
University Drive • Coral Gables, FL 33146

"Exhibit B"

Notification Letters
Sample of Each Notification Letter Attached

- **Physicians on Staff (Sent via Certified Mail) Exhibit 1**
  OB / GYN - See Attached Roster Listing
  Neonatologists - See Attached Roster Listing
- **OB / Gyn Physician Tenants (Sent via Certified mail) Exhibit 2**
  Ramon Iglesias, MD
  Pedro Villa, MD / Beatrice Hecker, MD
  Letty Villa, MD / Jean Thresher, MD
- **Emergency Medical Services Providers (Sent via Certified Mail) Exhibit 3**
  American Medical Response
  City of Miami - Fire Rescue Department
  Metro-Dade County - Fire Rescue Department
  Florida Medi-Van Ambulance Service
  City of Coral Gables - Fire Rescue Department
- **Press Statement - Exhibit 4**
- **HealthSouth Doctors' Hospital Employees - Exhibit 5**

ALTHSOUTH
rs' Hospital

August 31, 1999

EXHIBIT 1

Edward Fidalgo, MD
3659 S. Miami Avenue #5005
Miami, FL 33133

Dear Dr. Fidalgo:

This past week a decision was made to discontinue Obstetrical services at this facility effective October 1, 1999. This was a very difficult decision, but after reviewing several factors associated with this service, it was evident that the effects of reduced reimbursements and escalating costs would not allow this to continue to be a viable program at this facility.

The health care industry is undergoing many changes both on a national and local level. The acute care hospitals have been significantly affected by the Balanced Budget Act that was recently enacted by the government. This new legislation has not only affected the Acute Care Industry, it has also affected the Nursing Home Industry and the Home Health Industry. While all of these health care providers are experiencing an increase in their cost of providing services, the reimbursements for these services have been significantly reduced or have not kept pace with inflationary costs. The end result is that providers are being forced to reevaluate services being provided, and to take the necessary steps to ensure the long term financial viability of the institution. In addition, the reimbursements for this service has not increased over the past few years while the costs of providing this specialized service continues to escalate.

Again, this was a very difficult decision to make but a necessary one in order to ensure the viability of this institution. As always, thank you for your many years of support to this facility and please do not hesitate to contact me at 305-669-3401 if you have any questions or need additional information.

Sincerely,

Lincoln S. Mendez
Chief Executive Officer

EXHIBIT 1

HEALTHSOUTH Doctors' Hospital
PHYSICIAN LISTING BY SPECIALTY

AUGUST 02, 19

*** GYNECOLOGY ***

PHYSICIAN	ADDRESS	PHONE
MIGUEL ALBERT, M.D.	3659 S MIAMI AVE STE 6001 MIAMI, FL 33133	856-2828
JAMES N. ALLEYN	3661 S MIAMI AVE #208 MIAMI, FL 33133	854-3603
PEDRO J. ALVAREZ, M.D.	7300 S.W. 62ND PLACE PH LEVEL SOUTH MIAMI, FL 33143	662-9320
FERNANDO J. ALVAREZ-PEREZ, M.D.	3661 S MIAMI AVE STE 106 MIAMI, FL 33133	854-9966
LORI J. ARNOLD,M.D.	8950 N. KENDALL DRIVE SUITE 103 MIAMI, FL 33176	596-4013
S. ALLEN BRADFORD, M.D.	6280 SUNSET DR. SOUTH MIAMI, FL 33143	667-4511
DARRYL C. BROOKS, M.D.	7400 N KENDALL DR#210 MIAMI, FL 33156	670-9163
ISIDRO A. CARDELLA, M.D.	5000 UNIVERSITY DRIVE THIRD FLOOR CORAL GABLES, FL 33146	971-0510
MACARENA CARRETERO, M.D	6280 SUNSET DR SUITE 603 SOUTH MIAMI, FL 33143	665-8223

HEALTHSOUTH Doctors' Hospital
PHYSICIAN LISTING BY SPECIALTY

AUGUST 02, 1999

*** GYNECOLOGY ***

PHYSICIAN	ADDRESS	PHONE
NELSON P. CHAMBLESS, M.D.	9000 SW 87 CT SUITE 217 MIAMI, FL 33176	598-3437
CARLOS E. DECESPEDES, M.D.	3661 S.MIAMI AVE SUITE 505 MIAMI, FL 33133	854-8112
ROLANDO J. DELEON, M.D.	3661 S MIAMI AVE STE 504 MIAMI, FL 33133	854-2899
CESARE A.O. DIROCCO, M.D.	3661 S.MIAMI AVE SUITE 109 MIAMI, FL 33133	856-6051
SCOTT J. DUNKIN, D.O.	8224 MILLS DRIVE MIAMI, FL 33183	595-1300
EDWARD M. FIDALGO, M.D.	3659 S. MIAMI AVENUE SUITE 5005 MIAMI, FL 33133	854-2899
SUSAN FOX, D.O.	8224 MILLS DRIVE MIAMI, FL 33183	595-1300
JORGE L. GOMEZ, M.D.	7300 SW 62 PLACE 2ND FLOOR SOUTH MIAMI, FL 33143	669-9521
BEATRICE R. HECKER, M.D.	1150 CAMPO SANO AVE. #403 CORAL GABLES, FL 33146	667-8418

HEALTHSOUTH Doctors' Hospital
PHYSICIAN LISTING BY SPECIALTY

AUGUST 02, 199

*** GYNECOLOGY ***

PHYSICIAN	ADDRESS	PHONE
CAROLINE B. HUNTER, M.D.	1150 CAMPO SANO AVE SUITE 400 CORAL GABLES, FL 33146	669-3373
RAMON J. IGLESIAS, M.D.	5000 UNIVERSITY DRIVE 3RD FLOOR CORAL GABLES, FL 33146	661-0088
ROLANDO E. LACAYO, M.D.	11760 BIRD ROAD SUITE 311 MIAMI, FL 33175	553-1253
ANTHONY R. LAI, MD	7300 SW 62 PL SOUTH MIAMI, FL 33143	669-9521
JUAN J. LUGO, M.D.	8955 SW 87 CT SUITE 210 MIAMI, FL 33176	274-2490
JORGE E. MENDIA, M.D.	3661 S MIAMI AVE STE 1001 MIAMI, FL 33133	854-2899
WILLIAM T. MIXSON, JR., M.D.	8820 SW 67 CT MIAMI, FL 33156	667-7768
STAFFAN R.B. NORDQVIST,M.D.	1295 NW 14 ST, STE H MIAMI, FL 33125	324-7300
STEVEN R. POLIAKOFF, M.D.	6262 SUNSET DRIVE SUITE 308 SOUTH MIAMI, FL 33143	596-0870

HEALTHSOUTH Doctors' Hospital
PHYSICIAN LISTING BY SPECIALTY

AUGUST 02, 1999

*** GYNECOLOGY ***

PHYSICIAN	ADDRESS	PHONE
JAIME L. SEPULVEDA, M.D.	7300 S.W. 62 PLACE PENTHOUSE LEVEL SOUTH MIAMI, FL 33143	669-6267
MANUEL SUAREZ-MENDIAZABAL,M.D.	3661 S.MIAMI AVE SUITE 710 MIAMI, FL 33173	445-5407
ALISON J. THRESHER,M.D.	1150 CAMPO SANO AVE #400 CORAL GABLES, FL 33146	669-3990
FRANCISCO TUDELA,M.D.	777 E. 25 STREET #206 HIALEAH, FL 33013	691-1171
LETTY M. VILLA, M.D.	1150 CAMPO SANO AVE SUITE 400 CORAL GABLES, FL 33146	669-3990
PEDRO A. VILLA, M.D.	1150 CAMPO SANO AVE. #403 CORAL GABLES, FL 33146	667-8418
DONALD C. WILLIS, M.D.	7300 SW 62 PL 2ND FL SOUTH MIAMI, FL 33143	669-9521

*** PEDIATRICS ***

PHYSICIAN	ADDRESS	PHONE
ANA M. DUARTE, M.D.	3100 S.W. 62 AVE SUITE 303 MIAMI, FL 33155	669-6535
JAIME EDELSTEIN, M.D.	400 UNIVERSITY DR 3RD FLOOR CORAL GABLES, FL 33134	444-6882
MARIA V. EGUSQUIZA, M.D.	3220 SW 107 AVENUE MIAMI, FL 33165	551-1195
LORI A. FEIN, M.D.	8780 SW 92 STE STE 100 MIAMI, FL 33176	271-4711
ANN MARY FERNANDEZ-SOTO, MD	11209 SW 152 ST MIAMI, FL 33157	234-3441
MARIA-CATALINA FORTUN, M.D.	7755 S.W. 87TH AVE. SUITE 130 MIAMI, FL 33173	279-3332
JAY C. FRANKLIN, M.D.	8525 S.W. 92nd STREET MIAMI, FL 33156	871-4904
PHILIP GEORGE,M.D.	9000 S.W. 137TH AVE SUITE 204 MIAMI, FL 33186	385-2065
YAMIL GUERRA-NEGRETE, M.D.	12510 SW 88 ST MIAMI, FL 33186	270-1213

*** PEDIATRICS ***

PHYSICIAN	ADDRESS	PHONE
PHILLIP NEWCOMM, M.D.	305 GRANELLO AVENUE CORAL GABLES, FL 33146	446-2546
JOSE A. NODAR, M.D.	7000 SW 97 AVE #801 MIAMI, FL 33173	273-8521
MARIA E. OLIVER, M.D	7755 S.W 87th AVENUE SUITE #130 MIAMI, FL 33173	279-3332
JOSE I. PRADERE, M.D.	1200 SW 20 ST STE 601 MIAMI, FL 33145	856-6371
GENOVEVA C. PRIETO, M.D.	8851 S.W. 58TH STREET MIAMI, FL 33173	595-3316
WARREN W. QUILLIAN, II, M.D.	305 GRANELLO AVE. CORAL GABLES, FL 33146	446-2546
GRIFFITH E. QUINBY,M.D.	DIVISION OF NEONATOLOGY 3100 SW 62 AVE MIAMI, FL 33155	663-8469
LYDIA M. QUINTERO, M.D.	7755 S.W. 87TH AVE. MIAMI, FL 33173	279-3332
ANTONIO J. REYES, M.D.	1350 S.W 57th AVE SUITE #314 MIAMI, FL 33144	267-2182

HEALTHSOUTH
Doctors' Hospital

EXHIBIT 2

September 1, 1999

Ramon Iglesias, MD
5000 University Drive 3rd Floor
Coral Gables, FL 33146

Dear Dr. Iglesias:

As you are aware, the decision was made to discontinue Obstetrical Services at HEALTHSOUTH Doctors' Hospital effective October 1, 1999. Since you are currently leasing medical office space from HEALTHSOUTH at this location, I wanted to give you an opportunity to meet with me and review the current terms of your lease and to discuss the possibility of having an early termination of your lease without penalty.

You have been a major supporter of this institution for many years, therefore, I wanted to provide you with an option of possibly relocating your office to a site that would be more practical to your service area. If you are interested in exploring this possibility, please contact my office to arrange a meeting for this purpose. Please contact me if you have any questions or need additional information.

Sincerely,

Lincoln S. Mendez
Chief Executive Officer

HEALTHSOUTH
Doctors' Hospital

EXHIBIT 3

August 31, 1999

American Medical Response
7255 NW 19 Street
Miami, FL 33126

Dear Sir:

This letter is to inform you that effective 10/01/99, at 12:01 a.m. HealthSouth Doctors' Hospital will be closing the Labor & Delivery / Obstetrical Services. In accordance with state requirements, we have notified the State of Florida regarding the discontinuation of this service. This affects only obstetrical services. HealthSouth Doctors' Hospital will continue to provide gynecological services to the community.

Please note the effective date of this service change and notify the appropriate personnel. Area hospitals who provide obstetrical services have also been notified of this change.

Please contact my office at (305) 669-3401 if you need any additional information.

Sincerely,

Lincoln S. Mendez
Chief Executive Officer

EXHIBIT 4

PRESS STATEMENT

September 8, 1999

On August 31, 1999, Doctors' Hospital provided notification to the appropriate regulatory agencies, medical staff, and employees, that it would be discontinuing obstetrical services effective October 1, 1999. The Hospital is coordinating the transition of this service to neighboring facilities which provide obstetrical care.

Although only about one half of the Hospitals in Dade County provide Obstetrical services, three of those facilities are within a five mile radius of Doctors' Hospital. We represent less than 10% of the total deliveries within this area. Additionally, within eight miles of Doctors' Hospital, there are five other facilities that provide obstetrical services.

On a national level, acute care hospitals have been significantly impacted by the Balanced Budget Act recently enacted by the government. Acute care hospitals are experiencing an increase in their costs for providing services, while the reimbursements have been significantly reduced and have not kept pace with rising costs. All providers are being forced to reevaluate the services being provided and take necessary steps to ensure the long term financial viability of their institution.

The obstetricians on staff currently have medical staff privileges at neighboring facilities and will be able to transition their practices with minimal disruption.

We are working closely with our employees from the OB unit to transfer them into current open nursing positions within Doctors' Hospital. The other area hospitals with obstetrical services have been contacted to obtain their employment opportunities.

This difficult decision was reached in order to ensure our continued growth and long term commitment to the community.

EXHIBIT 5

September 3, 1999

Dear Fellow Employee:

I want to take this opportunity to update you on a very important matter regarding HEALTHSOUTH Doctors' Hospital. A decision has been made to discontinue obstetrical services at this facility effective October 1, 1999, at 12:01 A.M.. This was a very difficult decision, but after reviewing several factors associated with this service, I believe this action will contribute to our continued growth and financial viability.

The health care industry is undergoing many changes both on a local and national level. During the past few months there have been newspaper articles regarding the financial hardships and significant employee reductions at neighboring hospitals. Additionally on a national level, acute care hospitals have been significantly affected by the Balanced Budget Act recently enacted by the government. This new legislation has had a major impact on the acute care, nursing home, and the home health industry. While all of these health care providers are experiencing an increase in their cost of providing services, the reimbursements have been significantly reduced and have not kept pace with inflationary costs. Providers are being forced to reevaluate the services being provided and take necessary steps to ensure the long term financial viability of the institution.

As a result of this change, the employees in the Labor and Delivery Department will be provided the opportunity to consider transfers to currently vacant positions for which they may qualify. It is our hope to retain those employees who are committed to the hospital and your support to them during this transition is appreciated. Additionally, as this change will also affect employees (and family members) on our medical plan who require obstetrical care, we are working with other area healthcare providers to ensure a smooth transition of services.

HEALTHSOUTH Doctors' Hospital continues to grow and we are currently undertaking significant renovations in the Operating Room and other areas of the hospital in order to meet the current and future needs of our community. As always, thank you for your continued support and dedication to this facility.

Sincerely,

Lincoln S. Mendez
Chief Executive Officer

RUTLEDGE, ECENIA, PURNELL & HOFFMAN
PROFESSIONAL ASSOCIATION
ATTORNEYS AND COUNSELORS AT LAW

STEPHEN A. ECENIA
JOHN R. ELLIS
KENNETH A. HOFFMAN
THOMAS W. KONRAD
MICHAEL G. MAIDA
J. STEPHEN MENTON
R. DAVID PRESCOTT
HAROLD F. X. PURNELL
GARY R. RUTLEDGE

POST OFFICE BOX 551, 32302-0551
215 SOUTH MONROE STREET, SUITE 420
TALLAHASSEE, FLORIDA 32301-1841

TELEPHONE (850) 681-6788
TELECOPIER (850) 681-6515

OF COUNSEL:
CHARLES F. DUDLEY

GOVERNMENTAL CONSULTANTS:
PATRICK R. MALOY
AMY J. YOUNG

July 29, 1999

RECEIVED
JUL 29 1999
CON/BUDGET
REVIEW OFFICE
9900320

VIA HAND DELIVERY

Scott L. Hopes, Bureau Chief
Certificate of Need & Financial Analysis
Agency for Health Care Administration
2727 Mahan Drive
Building 3, Room 1221
Tallahassee, FL 32308

Re: Certificate of Need Exemption Request/St. Anthony's Hospital

Dear Mr. Hopes:

I am the authorized representative of St. Anthony's Hospital ("St. Anthony's") and Bayfront Medical Center ("Bayfront") and submit this letter on their behalf.

By correspondence dated June 29, 1999 (attached), Ms. Sue Brody, President and CEO, Bayfront-St. Anthony's Health Care, notified George Schaffer, AHCA Health Services and Facilities Consultant, of the discontinuation of obstetrical services at St. Anthony's. By correspondence dated July 14, 1999 (attached), Mr. Schaffer requested St. Anthony's obtain a Letter of Exemption from the Certificate of Need ("CON") office.

Accordingly, this letter requests your determination that the discontinuation of obstetrical services at St. Anthony's does not constitute a project subject to CON review pursuant to Section 408.036(3), Florida Statutes. As set forth in Ms. Brody's June 29, 1999 letter, high quality obstetrical services will remain available at nearby Bayfront. St. Anthony's and Bayfront are affiliated through BayCare Health System and Bayfront-St. Anthony's Health Care.

Should you have any questions or require additional information, please do not hesitate to contact me.

Sincerely,

Thomas W. Konrad

TWK/pjc
Attachments

STANTHON\HOPES.729

BAYFRONT-ST. ANTHONY'S
HEALTH CARE

June 29, 1999

Mr. George Schaffer
Health Services and Facilities Consultant
Office of Licensure and Certification
Agency for Health Care Administration
2727 Mahan Drive
Building 1, Room 254
Tallahassee, FL 32308

Re: Discontinuation of obstetrical services at St. Anthony's Hospital

Dear Mr. Schaffer:

I am the authorized representative of St. Anthony's Hospital ("St. Anthony's") and Bayfront Medical Center ("Bayfront"). The purpose of this correspondence is to notify the Agency that effective immediately, St. Anthony's will no longer provide obstetrical services. High quality obstetrical services will remain available at nearby Bayfront. St. Anthony's and Bayfront are affiliated through BayCare Health System and Bayfront-St. Anthony's Health Care.

Thank you for your assistance in this matter and please do not hesitate to contact me if you have any questions or require additional information.

Sincerely,

Sue Brody
President and CEO
Bayfront-St. Anthony's Health Care

STATE OF FLORIDA
AHCA
AGENCY FOR HEALTH CARE ADMINISTRATION

JEB BUSH, GOVERNOR — RUBEN J. KING-SHAW, JR., DIRECTOR

July 14, 1999

Sue Brody
Bayfront-St. Anthony's Health Care
701 Sixth St. South
St. Petersburg, FL 33701-4891

Re: Discontinuance of obstetrical services at St. Anthony's Hospital

Dear Ms. Brody:

This letter is in regard to your request to discontinue of obstetrical services at St. Anthony's Hospital.

Before we can process this request, we need the following:

- Letter of Exemption from review from the Agency's Certificate of Need Office

If you would like to discuss this further or if you have any questions, please feel free to contact me at (850) 487-2717.

Sincerely,

George J. Schaffer, Jr.
Health Services and Facility Consultant
Hospital & Outpatient Services
Health Facility Compliance

2727 MAHAN DRIVE TALLAHASSEE, FL 32308

07/20/99 [illegible]

AHCA
AGENCY FOR HEALTH CARE ADMINISTRATION

August 2, 1999

Mr. Thomas W. Konrad
Rutledge, Ecenia, Purnell & Hoffman
Attorneys and Counselors At Law
Post Office Box 551
Tallahassee, Florida 32302-0551

Re: Discontinuation of Obstetrical Services
Exemption #9900320
St. Anthony's Hospital
Pinellas County

Dear Mr. Konrad:

Thank you for your July 29 letter requesting an exemption for the discontinuation of obstetrical services. Your letter is being responded to as the authorized representative, as represented by your letter, to act on behalf of the license holder, St. Anthony's Hospital, Inc., for the facility of St. Anthony's Hospital. Specifically, you describe the proposed project as follows:

The discontinuation of obstetrical services at St. Anthony's Hospital.

Section 408.036(3)(l), *Florida Statutes*, eliminates certificate of need review for the termination of a health care service.

Therefore, based on the above information which was relied upon in making this determination, your proposed project is not subject to certificate of need review.

If any elements of this project should change, please notify this office in order to ensure the project is still not subject to review. If I may be of further assistance, please let me know.

Sincerely,

Karen Rivera
Health Services & Facilities Consultant Supervisor
Certificate of Need

KR:kwb

cc: Suncoast Health Council, Inc.
Plans and Construction, Skip Gregory, Bob Garland
Health Facility Regulation

STATE OF FLORIDA
[illegible] TALLAHASSEE FLORIDA • 32308

Law Offices
HOLLAND & KNIGHT LLP

315 South Calhoun Street
Suite 600
P.O. Drawer 810 (ZIP 32302-0810)
Tallahassee, Florida 32301

850-224-7000
FAX 850-224-8832
www.hklaw.com

FILE

Atlanta, Boca Raton, Boston, Fort Lauderdale, Jacksonville, Lakeland, Melbourne, Mexico City, Miami, New York, Northern Virginia, Orlando, Providence, San Francisco, St. Petersburg, Tampa, Washington, D.C., West Palm Beach

October 12, 1999

JEROME W. HOFFMAN
850-425-5654

Internet Address:
jhoffman@hklaw.com

VIA FACSIMILE

Mr. Ruben J. King-Shaw, Jr.
Director
Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, Florida 32308

Re: Florida Hospital Kissimmee

Dear Mr. King-Shaw:

This will advise you that, pursuant to the terms of the January 5, 1998 Agreement between Adventist Health Systems, AHCA and Columbia/HCA and at the request of Columbia/HCA, as of November 7, 1999, Florida Hospital Kissimmee will no longer accept new admissions for inpatient obstetrical services. Florida Hospital Kissimmee will cease providing obstetrical services on November 12, 1999. This letter is intended to constitute the 30-day notice which was promised in my letter of October 6, 1999, and in lieu of notices under Chapters 395 or 408, Florida Statutes.

Sincerely,

HOLLAND & KNIGHT LLP

Jerome W. Hoffman

JWH/cb
cc: Julie Gallagher
Liz Dudek
Diane Barganier
Patricia A. Conners/Kim King
Scott L. Hopes
Stephen Boone

TAL1 #205960 v1

Law Offices
HOLLAND & KNIGHT LLP

315 South Calhoun Street
Suite 600
P.O. Drawer 810 (ZIP 32302-0810)
Tallahassee, Florida 32301

850-224-7000
FAX 850-224-8832
www.hklaw.com

Emergency 408.036(3)(1) FS.
OC
11-22-99

Atlanta | Northern Virginia
Boston | Orlando
Fort Lauderdale | Providence
Jacksonville | San Francisco
Lakeland | St. Petersburg
Melbourne | Tallahassee
Mexico City | Tampa
Miami | Washington, D.C.
New York | West Palm Beach

JEROME W. HOFFMAN
850-425-5654

Internet Address:
jhoffman@hklaw.com

November 16, 1999

9900478

RECEIVED
NOV 18 1999
CON/BUDGET
REVIEW OFFICE

Scott L. Hopes
Bureau Chief
Certificate of Need & Financial Analysis
Agency for Health Care Administration
2727 Mahan Drive, Building 3
Tallahassee, Florida 32308

Dear Scott:

Thank you for your letter of November 9, 1999. As an initial matter, I believe that most of the data that you have requested are already on file with AHCA or other publicly available sources. Nevertheless, Florida Hospital will provide you with the following information in response to your request. under Section 408.036(3)(a), Florida Statutes:

1. Board Minutes. The Board has not specifically approved the termination of obstetric services at Florida Hospital Kissimmee but the Board did specifically approve the Settlement Agreement entered into on January 5, 1998, between Florida Hospital, Columbia/HCA Healthcare and the Agency which specifically contemplates the possibility that Florida Hospital Kissimmee might have to terminate the provision of obstetric services.

2. Current Deliveries. During the period from November 1, 1998, through October 31, 1999, Florida Hospital Kissimmee delivered 430 babies.

3. Emergency Medical Service Notification. See attached.

4. Notification to Patients. Florida Hospital made calls to physicians who are on staff for OB/GYN services who in turn notified their patients of the termination of obstetric services at Florida Hospital Kissimmee.

5. OB Payor Mix.

1998:

Medicaid	20%
Capitation Contract	8%
Commercial	2%
HMO	52%
PPO	15%
SP	3%

January – July 1999:

Medicaid	16%
Capitation Contract	7%
Commercial	3%
HMO	47%
PPO	19%
SP	8%

6. Policies and Procedures for Emergency Room Personnel; Management of Active Labor Patients. See attached.

7. Number of Beds to Be Delicensed or Reclassified. None.

8. Cost Associated with Termination of Obstetrical Services. None.

9. Gross Square Feet of Affected Space. 5,923.

10. Alternative uses for space. At the present time, Florida Hospital plans to use this space for outpatient services However, Florida Hospital

reserves the right to use the space for any service not subject to CON review subject to all applicable licensure rules and standards.

Very truly yours,

HOLLAND & KNIGHT LLP

Jerome W. Hoffman

JWH/cb
Attachments
cc: Rich Morrison

TAL1 #207638 v1

ATTACHMENT #3

FLORIDA HOSPITAL
Kissimmee

200 Hilda Street
Kissimmee, Florida 34741
(407) 846-4343

October 6, 1999

Mr. Rob Magnaghi, County Manager
17 S. Vernon Avenue, Room 112
Kissimmee, FL 34741

Dear Mr. Magnaghi:

Today, Florida Hospital regretfully announced that our obstetric services at Florida Hospital Kissimmee will close at 11:59 p.m. on November 7, 1999.

This decision is an outgrowth of our 1998 Certificate of Need agreement (involving Florida Hospital Kissimmee and Florida Hospital Celebration Health) with the State of Florida. The agreement allowed Columbia/HCA Health System to request closure of our obstetrics services if Osceola Regional Medical Center's market share in obstetrics dropped by one point or more. Even though Osceola Regional's actual number of births has increased, their market share has declined slightly – and Osceola Regional has chosen to exercise this option.

While we are sorry to stop offering obstetric services, I want to assure you that we will continue to provide high quality and fairly priced maternity services at Florida Hospital Celebration Health. We will work with our physicians and patients to make their transition as smooth as possible. The Florida Hospital Kissimmee employees affected by this change will be offered jobs elsewhere at Florida Hospital.

As always, we appreciate your continuing friendship and guidance. We at Florida Hospital Kissimmee plan to be here for a very long time, and we resolve to strengthen our services and expand our offerings to this community. Thank you for your support – today and in the future.

Sincerely,

Ken

Kenneth W. Bradley
Chief Executive Officer
Florida Hospital Kissimmee

FLORIDA HOSPITAL
Kissimmee

200 Hilda Street
Kissimmee, Florida 34741
(407) 846-4343

October 6, 1999

Mr. Mark Durbin, City Manager
City of Kissimmee
101 N. Church Street
Kissimmee, FL 34741

Dear Mr. Durbin:

Today, Florida Hospital regretfully announced that our obstetric services at Florida Hospital Kissimmee will close at 11:59 p.m. on November 7, 1999.

This decision is an outgrowth of our 1998 Certificate of Need agreement (involving Florida Hospital Kissimmee and Florida Hospital Celebration Health) with the State of Florida. The agreement allowed Columbia/HCA Health System to request closure of our obstetrics services if Osceola Regional Medical Center's market share in obstetrics dropped by one point or more. Even though Osceola Regional's actual number of births has increased, their market share has declined slightly – and Osceola Regional has chosen to exercise this option.

While we are sorry to stop offering obstetric services, I want to assure you that we will continue to provide high quality and fairly priced maternity services at Florida Hospital Celebration Health. We will work with our physicians and patients to make their transition as smooth as possible. The Florida Hospital Kissimmee employees affected by this change will be offered jobs elsewhere at Florida Hospital.

As always, we appreciate your continuing friendship and guidance. We at Florida Hospital Kissimmee plan to be here for a very long time, and we resolve to strengthen our services and expand our offerings to this community. Thank you for your support – today and in the future.

Sincerely,

Ken

Kenneth W. Bradley
Chief Executive Officer
Florida Hospital Kissimmee

Operated by the
Seventh-day Adventist Church

FLORIDA HOSPITAL
Kissimmee

200 Hilda Street
Kissimmee, Florida 34741
(407) 846-4343

October 6, 1999

Chief John Chapman
City of Kissimmee Fire Dept.
101 N. Church Street
Kissimmee, FL 34741

Dear Chief Chapman:

Today, Florida Hospital regretfully announced that our obstetric services at Florida Hospital Kissimmee will close at 11:59 p.m. on November 7, 1999.

This decision is an outgrowth of our 1998 Certificate of Need agreement (involving Florida Hospital Kissimmee and Florida Hospital Celebration Health) with the State of Florida. The agreement allowed Columbia/HCA Health System to request closure of our obstetrics services if Osceola Regional Medical Center's market share in obstetrics dropped by one point or more. Even though Osceola Regional's actual number of births has increased, their market share has declined slightly – and Osceola Regional has chosen to exercise this option.

While we are sorry to stop offering obstetric services, I want to assure you that we will continue to provide high quality and fairly priced maternity services at Florida Hospital Celebration Health. We will work with our physicians and patients to make their transition as smooth as possible. The Florida Hospital Kissimmee employees affected by this change will be offered jobs elsewhere at Florida Hospital.

As always, we appreciate your continuing friendship and guidance. We at Florida Hospital Kissimmee plan to be here for a very long time, and we resolve to strengthen our services and expand our offerings to this community. Thank you for your support – today and in the future.

Sincerely,

Ken

Kenneth W. Bradley
Chief Executive Officer
Florida Hospital Kissimmee

Operated by the
Seventh-day Adventist Church

FLORIDA HOSPITAL
Kissimmee

200 Hilda Street
Kissimmee, Florida 34741
(407) 846-4343

October 6, 1999

Chief Matt Meyers
Osceola County Fire & Rescue
108 West Drury Avenue
Kissimmee, FL 34741

Dear Chief Meyers:

Today, Florida Hospital regretfully announced that our obstetric services at Florida Hospital Kissimmee will close at 11:59 p.m. on November 7, 1999.

This decision is an outgrowth of our 1998 Certificate of Need agreement (involving Florida Hospital Kissimmee and Florida Hospital Celebration Health) with the State of Florida. The agreement allowed Columbia/HCA Health System to request closure of our obstetrics services if Osceola Regional Medical Center's market share in obstetrics dropped by one point or more. Even though Osceola Regional's actual number of births has increased, their market share has declined slightly – and Osceola Regional has chosen to exercise this option.

While we are sorry to stop offering obstetric services, I want to assure you that we will continue to provide high quality and fairly priced maternity services at Florida Hospital Celebration Health. We will work with our physicians and patients to make their transition as smooth as possible. The Florida Hospital Kissimmee employees affected by this change will be offered jobs elsewhere at Florida Hospital.

As always, we appreciate your continuing friendship and guidance. We at Florida Hospital Kissimmee plan to be here for a very long time, and we resolve to strengthen our services and expand our offerings to this community. Thank you for your support – today and in the future.

Sincerely,

Ken

Kenneth W. Bradley
Chief Executive Officer
Florida Hospital Kissimmee

Operated by the
Seventh-day Adventist Church

FLORIDA HOSPITAL
Kissimmee

200 Hilda Street
Kissimmee, Florida 34741
(407) 846-4343

October 6, 1999

Chief Bill Brim
St. Cloud Fire & Rescue
915 Massachusetts Avenue
St. Cloud, FL 34769

Dear Chief Brim:

Today, Florida Hospital regretfully announced that our obstetric services at Florida Hospital Kissimmee will close at 11:59 p.m. on November 7, 1999.

This decision is an outgrowth of our 1998 Certificate of Need agreement (involving Florida Hospital Kissimmee and Florida Hospital Celebration Health) with the State of Florida. The agreement allowed Columbia/HCA Health System to request closure of our obstetrics services if Osceola Regional Medical Center's market share in obstetrics dropped by one point or more. Even though Osceola Regional's actual number of births has increased, their market share has declined slightly – and Osceola Regional has chosen to exercise this option.

While we are sorry to stop offering obstetric services, I want to assure you that we will continue to provide high quality and fairly priced maternity services at Florida Hospital Celebration Health. We will work with our physicians and patients to make their transition as smooth as possible. The Florida Hospital Kissimmee employees affected by this change will be offered jobs elsewhere at Florida Hospital.

As always, we appreciate your continuing friendship and guidance. We at Florida Hospital Kissimmee plan to be here for a very long time, and we resolve to strengthen our services and expand our offerings to this community. Thank you for your support – today and in the future.

Sincerely,

Ken

Kenneth W. Bradley
Chief Executive Officer
Florida Hospital Kissimmee

FLORIDA HOSPITAL
Kissimmee

200 Hilda Street
Kissimmee, Florida 34741
(407) 846-4343

October 6, 1999

Dr. Allan Pratt
610 Oak Commons Blvd.
Kissimmee, FL 34741

Dear Dr. Pratt:

Today, Florida Hospital regretfully announced that our obstetric services at Florida Hospital Kissimmee will close at 11:59 p.m. on November 7, 1999.

This decision is an outgrowth of our 1998 Certificate of Need agreement (involving Florida Hospital Kissimmee and Florida Hospital Celebration Health) with the State of Florida. The agreement allowed Columbia/HCA Health System to request closure of our obstetric services if Osceola Regional Medical Center's market share in obstetrics dropped by one point or more. Even though Osceola Regional's actual number of births has increased, their market share has declined slightly – and Osceola Regional has chosen to exercise this option.

While we are sorry to stop offering obstetric services at Kissimmee, I want to assure you that Florida Hospital will continue to work with you, and we ask your help in expanding our high quality and fairly priced maternity program at Florida Hospital Celebration Health into an even stronger one. We hope you and your patients will choose to use Celebration Health's spacious private maternity suites, and we will work with you to make the transition as smooth as possible.

As always, we appreciate your continuing friendship and guidance. We at Florida Hospital Kissimmee plan to be here for a very long time, and we resolve to strengthen our services and expand our offerings to this community – in order to serve your patients better. Thank you for your support – today and in the future.

Sincerely,

Kenneth W. Bradley
Chief Executive Officer

Operated by the
Seventh-day Adventist Church

FLORIDA HOSPITAL
Kissimmee

200 Hilda Street
Kissimmee, Florida 34741
(407) 846-4343

October 6, 1999

Dr. Thomas Ryan
601 East Oak Street
Suite A
Kissimmee, FL 34744

Dear Dr. Ryan:

Today, Florida Hospital regretfully announced that our obstetric services at Florida Hospital Kissimmee will close at 11:59 p.m. on November 7, 1999.

This decision is an outgrowth of our 1998 Certificate of Need agreement (involving Florida Hospital Kissimmee and Florida Hospital Celebration Health) with the State of Florida. The agreement allowed Columbia/HCA Health System to request closure of our obstetrics services if Osceola Regional Medical Center's market share in obstetrics dropped by one point or more. Even though Osceola Regional's actual number of births has increased, their market share has declined slightly – and Osceola Regional has chosen to exercise this option.

While we are sorry to stop offering obstetric services at Kissimmee, I want to assure you that we will continue to provide high quality and fairly priced maternity services at Florida Hospital Celebration Health. We will work with our OB/GYN physicians and patients to make their transition as smooth as possible. The Florida Hospital Kissimmee employees affected by this change will be offered jobs elsewhere at Florida Hospital.

As always, we appreciate your continuing friendship and guidance. We at Florida Hospital Kissimmee plan to be here for a very long time, and we resolve to strengthen our services and expand our offerings to this community – in order to serve your patients better. Thank you for your support – today and in the future.

Sincerely,

Kenneth W. Bradley
Chief Executive Officer

Operated by the
Seventh-day Adventist Church

ATTACHMENT #6

FLORIDA HOSPITAL — POLICY & PROCEDURE

MANUAL	POLICY NUMBER
ASSESSMENT OF THE PATIENT - Emergency Department	155.080-1
TITLE	**EFFECTIVE DATE**
IMPENDING BIRTHS/ORLANDO, ALTAMONTE, OR EAST ORLANDO, AND CELEBRATION	11 1 1 99
	LEVEL 3

POLICY: It is the policy of the Emergency Department at Florida Hospital Orlando, Altamonte, East Orlando, and Celebration to deliver all impending births not able to reach the OB floor/unit

RESP.PERSONS:
Registered Nurse (RN)
Licensed Practical Nurse (LPN)
ED Nursing Personnel
ED Physician
AC Receptionist
Information Page.

EQPT/FORMS:
BOA Pack
Personal Protective Equipment (PPE)
Infant Intubation Equipment

PROCEDURE:

PERSON	*ACTION*
RN, Information page	1. Send all walk-in OB patients with impending delivery who arrive at the ED in Orlando, Altamonte or East Orlando and are 14 weeks pregnant or more directly to Labor and Delivery for evaluation of appropriate intervention. NOTE: Do not make a chart on these patients.
	2. Take all OB patients with an impending delivery who are not able to get to Labor and Delivery in the designated room of the ED i.e., birth in X-ray or at ED entrance.
AC Receptionist	a. Make a chart
ED Physician	b. Examine the patient
RN, LPN	c. Assemble supplies and equipment.
RN, LPN, ED	d. Follow Labor and Delivery policy.
AC Receptionist	e. Make a chart on the New Born.
ED Nursing Personnel	f. Notify attending OB physician, In-patient Labor and Delivery Unit and/or Neonatal Unit of spontaneous birth.
	g. Call OB unit to obtain incubator immediately. NOTE: If BOA (Born Out of Asepsis) follow Labor and Delivery policy, "Spontaneous Delivery (Out of Asepsis) of Infant and Placenta Before Arrival to Labor and Delivery Unit" and Labor and Delivery policy, "Immediate Care of the New Born."

Continued On Next Page-----

FLORIDA HOSPITAL — POLICY & PROCEDURE

MANUAL	POLICY NUMBER
ASSESSMENT OF THE PATIENT - Emergency Department	155.080-2
TITLE	**EFFECTIVE DATE**
IMPENDING BIRTHS/ORLANDO, ALTAMONTE, OR EAST ORLANDO, AND CELEBRATION	111199
	LEVEL 3

PERSON	*ACTION*
ED Nursing Personnel	3. Place placenta in basin and remove from room. Follow Labor and Delivery policy "Placenta Disposition."
ED Nursing Personnel	4. If patient has no private OB physician or is not an OCC, OB patient, the patient is to be transferred via stretcher Info., Page to the OB unit under the care of the OB physician on walk-in call, after following Labor and Delivery policy, "Immediate Care of the Patient Postpartum." NOTE: Staff physicians alternate every other week with MFPU residents.

Approved By:
Nursing Operations: May, 1999
Nursing Executive Council: May, 1999

Administrative Director, Emergency Department

Chairman, Emergency Medicine

Chief Medical Officer

Original Date: 11/01/81 (355.533)
Replaces: 03/01/91 (355.533)
Replaces: 01/05/94 (355.533)
Replaces: 05/19/97 (155.080)

FLORIDA HOSPITAL — POLICY & PROCEDURE

MANUAL	POLICY NUMBER
ASSESSMENT OF THE PATIENT - Emergency Department	155.082
TITLE	**EFFECTIVE DATE**
IMPENDING BIRTHS: APOPKA, KISSIMMEE	111199
	LEVEL 3

POLICY: It is the policy of the Emergency Department at Florida Hospital Apopka, Kissimmee to deliver all impending births not able to be transported.

RESP.PERSONS:
ED Nursing Personnel
ED Physician
AC Receptionist.

EQPT/FORMS:
Baby Warmer
BOA pack
(PPE) Personal Protective Equipment
Infant intubation tray.

PROCEDURE:

PERSON	ACTION
RN, LPN, EMT	1. Take patient to OB/GYN room.
ED Physician	2. Examine the patient.
RN	3. Start IV line.
	4. If BOA (Born out of Asepsis) follow Labor and Delivery policy, "Spontaneous Delivery, Assisting With" and policy, "Care of the New Born Immediate."
	5. If patient has no private OB physician, the patient is to be transferred to a Florida Hospital OB Unit to be under the care of the OB physician on-call.
	6. If patient has a private OB physician, notify the physician and make a chart on newborn.
	7. Less than 20 weeks gestation - call GYN on-call.
	8. Greater than 20 weeks gestation, and in labor: (1) APOPKA: Call FPMG (Florida Physician Medical Group) on-call for OB, and assess if patient is stable enough for transfer to Florida Hospital Orlando, Labor & Delivery NOTE: If infant is delivered prior to the arrival, or is in ED, call the Florida Hospital Neonatal Transport Unit to transfer the infant.

Continued On Next Page-----

FLORIDA HOSPITAL — POLICY & PROCEDURE

MANUAL	POLICY NUMBER
ASSESSMENT OF THE PATIENT - Emergency Department	155.082
TITLE	**EFFECTIVE DATE**
IMPENDING BIRTHS: APOPKA, KISSIMMEE	111199
	LEVEL 3

(2) KISSIMMEE:
Call Celebration Health OB physician on-call and assess if patient is stable enough for transfer to Florida Hospital Celebration Labor & Delivery
NOTE: If infant is delivered prior to the arrival, or is in ED, call the Florida Hospital Neonatal Transport Unit to transfer the infant.

Original Date: 11/01/81 (355.534)
Replaces: 01/21/85 (355.534)
Replaces: 12/03/93 (355.534)
Replaces: 05/19/97 (155.082)

Administrative Director, Emergency Department

Chairman Emergency Medicine

Chief Medical Officer

STATE OF FLORIDA

AHCA

AGENCY FOR HEALTH CARE ADMINISTRATION

JEB BUSH, GOVERNOR

RUBEN J. KING-SHAW, JR., DIRECTOR

November 4, 1999

Mr. Jerome W. Hoffman
Law Offices
Holland & Knight, LLP
P.O. Drawer 810
Tallahassee, Florida 32302-0810

Dear Mr. Hoffman:

In response to your November 3 letter, please understand that we have a responsibility under the statutes to address the termination of a health care service (408.036(3)(1), Florida Statutes), irrespective of the unique elements of the situation inducing the termination. While I appreciate your position regarding the Settlement Agreement, I am obligated to ask Florida Hospital to provide the relevant information contained in my October 21 letter for our files.

Sincerely,

Scott L. Hopes
Bureau Chief
Certificate of Need & Financial Analysis

SLH:CEC:kwb

2727 MAHAN DRIVE TALLAHASSEE, FL 32308

Carter, Edwin

From: Gilroy, John
Sent: Thursday, November 04, 1999 10:43 AM
To: Carter, Edwin
Cc: Hopes, Scott; Gallagher, Julie; King-Shaw Jr. , Ruben
Subject: FH Kissimmee--OB termination

Karen
FYI
Ed C.

ED --
Thanks for copying me with the November 1 letter from Jerome Hoffman. As you told me, since FH Kissimmee notified us that they'd terminate OB services as of November 12, 1999, your office has treated it as a request for CON exemption, and asked FH to provide some standard documentation as to the terms and scope of the service termination. Jerome's letter seeks to confirm that the CON office is aware that the Celebration agreement is the basis for their action, and gives you some assurance that virtually all of the requested info can be provided. I would advise that you proceed on those terms, confirm to Jerome that we do want FH to provide us with the standard details, and move toward making a good record for CON exemption fot the termination of a health care service under Sec. 408.036(3)(l), F.S.

Any questions or further developments, give me a call. Thanks.

John

John F. Gilroy, Senior Attorney
Agency for Health Care Administration
Office of General Counsel
2727 Mahan Drive, Bldg. 3, Room 3409B
Tallahassee, Fl. 32308-5403
(850) 921-0078; SC 291-0078
gilroyj@fdhc.state.fl.us.com

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JEROME W. HOFFMAN
850-425-5654

Internet Address:
jhoffman@hklaw.com

November 1, 1999

RECEIVED
NOV 0 3 199
CON/BUDGET
REVIEW OFFICE

Scott L. Hopes
Bureau Chief
Certificate of Need & Financial Analysis
Agency for Health Care Administration
2727 Mahan Drive, Building 3
Tallahassee, Florida 32308

Dear Scott:

Thank you for your letter of October 21st concerning the discontinuation of obstetrical services at Florida Hospital Kissimmee. I am not sure that you are aware that the decision to discontinue obstetrical services at Florida Hospital Kissimmee was not a voluntary decision reached by the hospital. Under the terms of the January 5, 1998 Settlement Agreement between Osceola Regional/Columbia HCA, the Agency for Health Care Administration and Florida Hospital, Florida Hospital Kissimmee agreed to discontinue OB services at Kissimmee if Osceola Regional's market share for obstetrical services in Osceola County dropped in any calendar year period compared to 1997. Based upon data that was reported for 1998, it appears that Osceola Regional lost approximately 2 percent market share in OB services for deliveries in Osceola County, notwithstanding the fact that they actually increased their number of births in the county in 1998.

In any event, Osceola Regional elected to require Florida Hospital to discontinue obstetrical services at Kissimmee pursuant to the terms of that January 5, 1998 agreement. Prior to reaching the decision to terminate OB services at Kissimmee we had discussed the issue with Julie Gallagher and Ruben King-Shaw and they stated that they believed that the agreement was binding under these factual circumstances and would support its enforcement.

Under these circumstances, do you still want Florida Hospital to provide the requested information and seek an exemption under Section 408.036(3)(1),

Florida Statutes? Florida Hospital can probably provide all the requested information except a copy of the Board Minutes authorizing termination of OB services since the decision was one which was compelled by the Settlement Agreement, not specifically directed by the Board. We can represent that the Board was aware of the requirements of the Settlement Agreement when it was signed. Please let me know how you wish to proceed.

Very truly yours,

HOLLAND & KNIGHT LLP

Jerome W. Hoffman

JWH/jr
cc: Rich Morrison

TAL1 #206894 v1

Law Offices
HOLLAND & KNIGHT LLP

315 South Calhoun Street
Suite 600
P.O. Drawer 810 (ZIP 32302-0810)
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JEROME W. HOFFMAN
850-425-5654

Internet Address:
jhoffman@hklaw.com

October 12, 1999

VIA FACSIMILE

Mr. Ruben J. King-Shaw, Jr.
Director
Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, Florida 32308

RECEIVED
OCT 15 1999
CON/BUDGET
REVIEW OFFICE

Re: Florida Hospital Kissimmee

Dear Mr. King-Shaw:

This will advise you that, pursuant to the terms of the January 5, 1998 Agreement between Adventist Health Systems, AHCA and Columbia/HCA and at the request of Columbia/HCA, as of November 7, 1999, Florida Hospital Kissimmee will no longer accept new admissions for inpatient obstetrical services. Florida Hospital Kissimmee will cease providing obstetrical services on November 12, 1999. This letter is intended to constitute the 30-day notice which was promised in my letter of October 6, 1999, and in lieu of notices under Chapters 395 or 408, Florida Statutes.

Sincerely,

HOLLAND & KNIGHT LLP

Jerome W. Hoffman

JWH/cb
cc: Julie Gallagher
Liz Dudek
Diane Barganier
Patricia A. Conners/Kim King
Scott L. Hopes
Stephen Boone

TAL1 #205960 v1

Carter, Edwin

From: Hopes, Scott
Sent: Wednesday, November 03, 1999 9:06 AM
To: Carter, Edwin
Cc: Rivera, Karen
Subject: FW: Florida Hospital Kissimmee -- OB Services

Please get the necessary paperwork and issue the exemption to terminate the service.

Thank you,

Scott

-----Original Message-----
From: Gilroy, John
Sent: Tuesday, November 02, 1999 4:34 PM
To: King-Shaw Jr. , Ruben
Cc: Gallagher, Julie; MacLafferty, Laura; Hopes, Scott
Subject: Florida Hospital Kissimmee -- OB Services

Ruben --
This is to follow up on your recent question about Florida Hospital Kissimmee, and whether their proposed termination of obstetrical services is consistent with the Celebration agreement. As you recall, we determined several months ago that the condition set out in that agreement had been met, requiring termination of OB services at Kissimmee. Florida Hospital Kissimeee notified us by letter of Oct. 12 that they would cease providing obstetrical services on November 12, 1999. Pursuant to the agreement, FH Kissimmee could have continued operating through the end of the year. In fact, they had indicated in September that they'd seek an extension to Feb. 1, 2000, which we and Columbia may have been agreeable to, but then turned around and sent notice that they would shut it down as of November 12.

FH Kissimmee is within the terms of the agreement. Any questions or follow up, give me a call.

John

John F. Gilroy, Senior Attorney
Agency for Health Care Administration
Office of General Counsel
2727 Mahan Drive, Bldg. 3, Room 34098
Tallahassee, FL 32308-5403
(850) 921-0078; SC 291-0078
gilroyj@fdhc.state.fl.us.com

1

STATE OF FLORIDA
AHCA
AGENCY FOR HEALTH CARE ADMINISTRATION

JEB BUSH, GOVERNOR — RUBEN J. KING-SHAW, JR., DIRECTOR

October 21, 1999

Mr. Jerome W. Hoffman
Law Offices
Holland & Knight, LLP
P.O. Drawer 810
Tallahassee, Florida 32302-0810

Dear Mr. Hoffman:

This letter is in response to your October 12 letter regarding the discontinuation of obstetrical (OB) services at Florida Hospital Kissimmee. Termination of a health care service specifically requires an exemption from certificate of need review (408.036(3)(1), Florida Statutes). Please provide the following information so that the exemption request may be reviewed:

- A copy of the Board minutes authorizing termination of OB services at Florida Hospital Kissimmee.
- The current number of deliveries at Florida Hospital Kissimmee.
- Copies of written notification to Emergency Medical Services (EMS) regarding policies and procedures to re-route OB patients to another provider.
- Documentation of procedures for notifying patients who have pre-registered for delivery at Florida Hospital Kissimmee of the impending termination of OB.
- Documentation of the most recent 12-month period payer mix for OB care.
- Copies of policies and procedures for emergency room personnel for managing walk-in active labor patients.
- The number of beds to be delicensed/reclassified.
- The cost associated with termination of obstetrical services.
- The gross square feet of affected space.
- The intended use of space vacated by obstetrical service.

If you have any questions, please contact Karen Rivera, of my staff, or me at 488-8673.

Sincerely,

Scott L. Hopes
Bureau Chief
Certificate of Need & Financial Analysis

SLH:KR:kwb

cc: Local Health Council of East Central Florida, Inc.
Plans and Construction, Skip Gregory & Bob Garland
Health Facility Regulation, George Schaffer

2727 MAHAN DRIVE — TALLAHASSEE, FL 32308

Law Offices
HOLLAND & KNIGHT LLP

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JEROME W. HOFFMAN
850-425-5654

Internet Address:
jhoffman@hklaw.com

October 12, 1999

VIA FACSIMILE

Mr. Ruben J. King-Shaw, Jr.
Director
Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, Florida 32308

RECEIVED
OCT 15 1999
CON/BUDGET
REVIEW OFFICE

Re: Florida Hospital Kissimmee

Dear Mr. King-Shaw:

This will advise you that, pursuant to the terms of the January 5, 1998 Agreement between Adventist Health Systems, AHCA and Columbia/HCA and at the request of Columbia/HCA, as of November 7, 1999, Florida Hospital Kissimmee will no longer accept new admissions for inpatient obstetrical services. Florida Hospital Kissimmee will cease providing obstetrical services on November 12, 1999. This letter is intended to constitute the 30-day notice which was promised in my letter of October 6, 1999, and in lieu of notices under Chapters 395 or 408, Florida Statutes.

Sincerely,

HOLLAND & KNIGHT LLP

Jerome W. Hoffman

JWH/cb
cc: Julie Gallagher
Liz Dudek
Diane Barganier
Patricia A. Conners/Kim King
Scott L. Hopes
Stephen Boone

TAL1 #205960 v1

STATE OF FLORIDA

AHCA

AGENCY FOR HEALTH CARE ADMINISTRATION

JEB BUSH, GOVERNOR

RUBEN J. KING-SHAW, JR., DIRECTOR

November 22, 1999

Mr. Jerome W. Hoffman
Holland & Knight, LLP
315 South Calhoun Street, Suite 600
Tallahassee, Florida 32301

Re: Termination of Obstetrical Services
Exemption #9900478
Florida Hospital-Kissimmee
Osceola County

Dear Mr. Hoffman:

Thank you for your November 16 letter requesting an exemption for the discontinuation of obstetrical services. Your letter is being responded to as the authorized representative, as represented by your letter, to act on behalf of the license holder, Adventist Health System/Sunbelt, Inc., for the facility of Florida Hospital-Kissimmee. Specifically, you describe the proposed project as follows:

The termination of obstetrical services at Florida Hospital-Kissimmee.

Section 408.036(3)(l), *Florida Statutes*, eliminates certificate of need review for the termination of a health care service.

Therefore, based on the above information which was relied upon in making this determination, your proposed project is not subject to certificate of need review.

If any elements of this project should change, please notify this office in order to ensure the project is still not subject to review. If I may be of further assistance, please let me know.

Sincerely,

FOR Karen Rivera
Health Services & Facilities Consultant Supervisor
Certificate of Need & Financial Analysis

KR:kwb

cc: Local Health Council of East Central Florida, Inc.
Plans and Construction, Skip Gregory, Bob Garland
Health Facility Compliance, Hospital Section

2727 MAHAN DRIVE TALLAHASSEE, FL 32308

Aventura Hospital and Medical Center

20900 Biscayne Boulevard
Aventura, Florida 33180
(305) 682-7000
www.aventurahospital.com

RECEIVED
OCT 16 2002
HEALTH FACILITY REGULATION
HOSPITAL & OUTPATIENT SERVICES

October 10, 2002

Via Certified Return Receipt
#7001 1940 0001 7005 0670

Julio Gonzalez
Agency for Health Care Administration
Hospital and Outpatient Services Unit
2727 Mahan Drive, Bldg. 1
Tallahassee, FL 32308

Re: Aventura Hospital and Medical Center/Closure of Obstetrical Services

Dear Mr. Gonzalez:

The purpose of this letter is to advise you that Aventura intends to discontinue obstetrical services at the hospital effective November 27, 2002. It is my understanding that the State of Florida, Agency for Health Care Administration, requires no further notice pertaining to the closure of obstetrical services at Aventura.

Thank you for your attention to this matter. Please contact me immediately if you should have a different understanding or require additional information.

Sincerely,

Davide M. Carbone
Chief Executive Officer

DMC/tlc

cc: Steve Ecenia

AHCA

FRAES LE
Agency for Health Care Administration
License Lists

WITH DB

Board: 1010 HOSPITAL UNIT
License Type: 23 HOSPITAL
Sorted by: Inspection region, Name, Status, Licence #
Selection Criteria: Address type=ST; Modifier Type=S; Modifier=CL01; License status=20

File #	License #	Name	Rank	Status	Expires	Insp Region	County	Zip Code
100093	4456	BAPTIST HOSPITAL	Hospital	ACTIVE	06/30/2005	Area Office 1	ESCAMBIA	32501
100223	4363	FORT WALTON BEACH MEDICAL CENTER	Hospital	ACTIVE	06/26/2004	Area Office 1	OKALOOSA	32547-6708
100122	4298	NORTH OKALOOSA MEDICAL CENTER	Hospital	ACTIVE	03/15/2004	Area Office 1	OKALOOSA	32536
100025	4433	SACRED HEART HOSPITAL	Hospital	ACTIVE	06/30/2005	Area Office 1	ESCAMBIA	32504
100124	4342	SANTA ROSA MEDICAL CENTER	Hospital	ACTIVE	12/31/2003	Area Office 1	SANTA ROSA	32570
100231	4318	WEST FLORIDA HOSPITAL	Hospital	ACTIVE	06/30/2005	Area Office 1	ESCAMBIA	32514
100039	4128	BROWARD GENERAL MEDICAL CENTER	Hospital	ACTIVE	06/30/2005	Area Office 10	BROWARD	33316
110019	3954	CORAL SPRINGS MEDICAL CENTER	Hospital	ACTIVE	03/16/2005	Area Office 10	BROWARD	33065
100225	4416	HOLLYWOOD MEDICAL CENTER	Hospital	ACTIVE	01/04/2005	Area Office 10	BROWARD	33021
100073	4069	HOLY CROSS HOSPITAL, INC.	Hospital	ACTIVE	08/24/2005	Area Office 10	BROWARD	33308
100200	3996	IMPERIAL POINT MEDICAL CENTER	Hospital	ACTIVE	06/30/2005	Area Office 10	BROWARD	33308
111527	4316	MEMORIAL HOSPITAL WEST	Hospital	ACTIVE	05/11/2004	Area Office 10	BROWARD	33028
100038	4411	MEMORIAL REGIONAL HOSPITAL	Hospital	ACTIVE	06/30/2005	Area Office 10	BROWARD	33021
100189	4383	NORTHWEST MEDICAL CENTER	Hospital	ACTIVE	08/31/2004	Area Office 10	BROWARD	33063
100167	4384	PLANTATION GENERAL HOSPITAL	Hospital	ACTIVE	08/30/2004	Area Office 10	BROWARD	33317
100224	4402	UNIVERSITY HOSPITAL AND MEDICAL CENTER	Hospital	ACTIVE	01/25/2004	Area Office 10	BROWARD	33321
100008	4085	BAPTIST HOSPITAL OF MIAMI	Hospital	ACTIVE	06/30/2005	Area Office 11	DADE	33176
100009	4109	CEDARS MEDICAL CENTER	Hospital	ACTIVE	02/15/2005	Area Office 11	DADE	33136
100197	3988	DOUGLAS GARDENS HOSPITAL	Hospital	ACTIVE	06/30/2005	Area Office 11	DADE	33137
100053	4347	HIALEAH HOSPITAL	Hospital	ACTIVE	05/31/2004	Area Office 11	DADE	33013
100022	3998	JACKSON MEMORIAL HOSPITAL	Hospital	ACTIVE	06/30/2005	Area Office 11	DADE	33136
120008	3998	JACKSON MEMORIAL HOSPITAL-NORTH	Hospital Prem	ACTIVE	06/30/2005	Area Office 11	DADE	33054
100208	3998	JACKSON SOUTH COMMUNITY HOSPITAL	Hospital Prem	ACTIVE	06/30/2005	Area Office 11	DADE	33157
100209	4344	KENDALL REGIONAL MEDICAL CENTER	Hospital	ACTIVE	06/30/2005	Area Office 11	DADE	33175
100150	4302	LOWER KEYS MEDICAL CENTER	Hospital Prem	ACTIVE	04/30/2005	Area Office 11	MONROE	33040
100195	4302	LOWER KEYS MEDICAL CENTER	Hospital	ACTIVE	04/30/2005	Area Office 11	MONROE	33041-9107
100061	4002	MERCY HOSPITAL INC.	Hospital	ACTIVE	06/30/2005	Area Office 11	DADE	33133
100034	4066	MOUNT SINAI MEDICAL CENTER	Hospital	ACTIVE	06/29/2004	Area Office 11	DADE	33140
100029	4133	NORTH SHORE MEDICAL CENTER	Hospital	ACTIVE	01/10/2005	Area Office 11	DADE	33150-2098
100187	4313	PALMETTO GENERAL HOSPITAL	Hospital	ACTIVE	06/30/2004	Area Office 11	DADE	33016
100114	4455	PARKWAY REGIONAL MEDICAL CENTER	Hospital	ACTIVE	11/12/2003	Area Office 11	DADE	33169

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License Lists

Board: 1010 HOSPITAL UNIT
License Type: 23 HOSPITAL
Sorted by: Inspection region, Name, Status, Licence #
Selection Criteria: Address type=ST; Modifier Type=S; Modifier=CL01; License status=20

File #	License #	Name	Rank	Status	Expires	Insp Region	County	Zip Code
100154	4033	SOUTH MIAMI HOSPITAL	Hospital	ACTIVE	06/30/2005	Area Office 11	DADE	33143
100165	4068	WESTCHESTER GENERAL HOSPITAL	Hospital	ACTIVE	06/30/2005	Area Office 11	DADE	33155
100026	3982	BAY MEDICAL CENTER	Hospital	ACTIVE	06/30/2005	Area Office 2	BAY	32401
100242	4337	GULF COAST MEDICAL CENTER	Hospital	ACTIVE	06/30/2005	Area Office 2	BAY	32405
100254	4017	TALLAHASSEE COMMUNITY HOSPITAL	Hospital	ACTIVE	06/30/2005	Area Office 2	LEON	32308
100135	4080	TALLAHASSEE MEMORIAL HOSPITAL	Hospital	ACTIVE	06/30/2005	Area Office 2	LEON	32308
100023	4233	CITRUS MEMORIAL HOSPITAL	Hospital	ACTIVE	02/28/2004	Area Office 3	CITRUS	34452-4754
100057	4409	FLORIDA HOSPITAL WATERMAN	Hospital	ACTIVE	09/30/2004	Area Office 3	LAKE	32726
100084	4000	LEESBURG REGIONAL MEDICAL CENTER	Hospital	ACTIVE	06/30/2005	Area Office 3	LAKE	34748
100214	4000	LEESBURG REGIONAL MEDICAL CENTER-NORTH	Hospital Prem	ACTIVE	06/30/2005	Area Office 3	LAKE	34748
100062	4414	MUNROE REGIONAL MEDICAL CENTER	Hospital	ACTIVE	08/31/2004	Area Office 3	MARION	34478
100204	4247	NORTH FLORIDA REGIONAL MEDICAL CENTER	Hospital	ACTIVE	04/21/2004	Area Office 3	ALACHUA	32605-7006
100212	4001	OCALA REGIONAL MEDICAL CENTER	Hospital	ACTIVE	06/30/2005	Area Office 3	MARION	34474
100232	4350	PUTNAM COMMUNITY MEDICAL CENTER	Hospital	ACTIVE	06/15/2004	Area Office 3	PUTNAM	32178
100249	4116	SEVEN RIVERS COMMUNITY HOSPITAL	Hospital	ACTIVE	06/30/2005	Area Office 3	CITRUS	34428
100082	4286	SHANDS AT AGH	Hospital Prem	ACTIVE	01/31/2004	Area Office 3	ALACHUA	32601
100113	4286	SHANDS HOSPITAL AT UNIV. OF FLORIDA	Hospital	ACTIVE	01/31/2004	Area Office 3	ALACHUA	32610
111525	4217	SPRING HILL REGIONAL HOSPITAL	Hospital Prem	ACTIVE	12/27/2003	Area Office 3	HERNANDO	34609
23960032	4484	VILLAGES REGIONAL HOSPITAL, THE	Hospital	ACTIVE	07/11/2004	Area Office 3	SUMTER	32159
100088	4448	BAPTIST MEDICAL CENTER	Hospital	ACTIVE	06/30/2005	Area Office 4	DUVAL	32207
100117	4304	BAPTIST MEDICAL CENTER - BEACHES	Hospital	ACTIVE	04/30/2004	Area Office 4	DUVAL	32250
100219	3665	FLAGLER HOSPITAL	Hospital	ACTIVE	10/31/2003	Area Office 4	ST. JOHNS	32086
100169	4201	FLORIDA HOSPITAL - ORMOND MEMORIAL	Hospital	ACTIVE	06/30/2005	Area Office 4	VOLUSIA	32174
100045	4436	FLORIDA HOSPITAL DELAND	Hospital	ACTIVE	11/30/2004	Area Office 4	VOLUSIA	32721
100072	4408	FLORIDA HOSPITAL FISH MEMORIAL	Hospital	ACTIVE	09/30/2004	Area Office 4	VOLUSIA	32763
100017	4181	HALIFAX MEDICAL CENTER	Hospital	ACTIVE	06/30/2005	Area Office 4	VOLUSIA	32115
100179	4447	MEMORIAL HOSPITAL JACKSONVILLE	Hospital	ACTIVE	01/02/2005	Area Office 4	DUVAL	32216
100226	4354	ORANGE PARK MEDICAL CENTER	Hospital	ACTIVE	06/30/2005	Area Office 4	CLAY	32073
100151	4438	SAINT LUKE'S HOSPITAL	Hospital	ACTIVE	11/26/2004	Area Office 4	DUVAL	32216
100040	4376	SAINT VINCENT'S MEDICAL CENTER	Hospital	ACTIVE	12/30/2003	Area Office 4	DUVAL	32204

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rd: 1010 HOSPITAL UNIT
nse Type: 23 HOSPITAL
ed by: Inspection region, Name, Status, Licence #
ction Criteria: Address type=ST; Modifier Type=S; Modifier=CL01; License status=20

#	License #	Name	Rank	Status	Expires	Insp Region	County	Zip Code
01	4063	SHANDS JACKSONVILLE MEDICAL CENTER	Hospital	ACTIVE	09/29/2003	Area Office 4	DUVAL	32209
32	4303	BAYFRONT MEDICAL CENTER	Hospital	ACTIVE	06/30/2005	Area Office 5	PINELLAS	33701
91	4400	COMMUNITY HOSPITAL	Hospital	ACTIVE	06/30/2005	Area Office 5	PASCO	34656
46	4445	EAST PASCO MEDICAL CENTER,INC.	Hospital	ACTIVE	03/31/2004	Area Office 5	PASCO	33541
55	4333	HELEN ELLIS MEMORIAL HOSPITAL	Hospital	ACTIVE	06/30/2005	Area Office 5	PINELLAS	34689
43	4378	MEASE HOSPITAL - DUNEDIN	Hospital	ACTIVE	06/30/2005	Area Office 5	PINELLAS	34698
01	4378	MEASE HOSPITAL - COUNTRYSIDE	Hospital Prem	ACTIVE	06/30/2005	Area Office 5	PINELLAS	34695
27	4064	MORTON PLANT HOSPITAL	Hospital	ACTIVE	06/30/2005	Area Office 5	PINELLAS	33756
63	4216	MORTON PLANT NORTH BAY HOSPITAL	Hospital	ACTIVE	05/31/2005	Area Office 5	PASCO	34652
11	3935	PASCO REGIONAL MEDICAL CENTER	Hospital	ACTIVE	08/31/2004	Area Office 5	PASCO	33525-5294
56	4312	REGIONAL MEDICAL CENTER BAYONET POINT	Hospital	ACTIVE	04/01/2004	Area Office 5	PASCO	34667
80	3942	ST PETERSBURG GENERAL HOSPITAL	Hospital	ACTIVE	02/23/2005	Area Office 5	PINELLAS	33710
21	4428	BARTOW MEMORIAL HOSPITAL	Hospital	ACTIVE	12/04/2003	Area Office 6	POLK	33830
13	4323	BLAKE MEDICAL CENTER	Hospital	ACTIVE	04/30/2004	Area Office 6	MANATEE	34209
43	4403	BRANDON REGIONAL HOSPITAL	Hospital	ACTIVE	02/23/2005	Area Office 6	HILLSBOROUGH	33511
09	4171	FLORIDA HOSPITAL HEARTLAND MEDICAL CENTE	Hospital	ACTIVE	02/23/2005	Area Office 6	HIGHLANDS	33872-1200
13	4171	FLORIDA HOSPITAL-LAKE PLACID	Hospital Prem	ACTIVE	02/24/2005	Area Office 6	HIGHLANDS	33852
09	4334	H. LEE MOFFITT CANCER CTR & RESEARCH INS	Hospital	ACTIVE	06/30/2004	Area Office 6	HILLSBOROUGH	33612-9497
37	4385	HEART OF FLORIDA REGIONAL MEDICAL CENTER	Hospital	ACTIVE	08/21/2005	Area Office 6	POLK	33837
49	4321	HIGHLANDS REGIONAL MEDICAL CENTER	Hospital	ACTIVE	06/30/2005	Area Office 6	HIGHLANDS	33870
57	4413	LAKELAND REGIONAL MEDICAL CENTER	Hospital	ACTIVE	09/30/2004	Area Office 6	POLK	33805
35	4146	MANATEE MEMORIAL HOSPITAL	Hospital	ACTIVE	06/30/2005	Area Office 6	MANATEE	34208
32	4056	SOUTH FLORIDA BAPTIST HOSPITAL	Hospital	ACTIVE	06/30/2005	Area Office 6	HILLSBOROUGH	33566
75	4292	ST JOSEPH'S HOSPITAL INC.	Hospital	ACTIVE	06/30/2005	Area Office 6	HILLSBOROUGH	33677
28	4044	TAMPA GENERAL HOSPITAL	Hospital	ACTIVE	09/30/2005	Area Office 6	HILLSBOROUGH	33601
55	4043	TOWN & COUNTRY HOSPITAL	Hospital	ACTIVE	10/14/2003	Area Office 6	HILLSBOROUGH	33615
73	4035	UNIVERSITY COMMUNITY HOSPITAL	Hospital	ACTIVE	06/30/2005	Area Office 6	HILLSBOROUGH	33614

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File #	License #	Name	Rank	Status	Expires	Insp Region	County	Zip Code
100052	3974	WINTER HAVEN HOSPITAL	Hospital	ACTIVE	05/19/2005	Area Office 6	POLK	33881
120010	3974	WINTER HAVEN HOSPITAL-REGENCY	Hospital Prem	ACTIVE	05/18/2005	Area Office 6	POLK	33880
120001	4393	ARNOLD PALMER HOSPITAL	Hospital Prem	ACTIVE	06/30/2005	Area Office 7	ORANGE	32806
100177	3948	CAPE CANAVERAL HOSPITAL	Hospital	ACTIVE	03/06/2005	Area Office 7	BREVARD	32931
100161	4032	CENTRAL FLORIDA REGIONAL HOSPITAL	Hospital	ACTIVE	05/31/2005	Area Office 7	SEMINOLE	32771
100007	4369	FLORIDA HOSPITAL	Hospital	ACTIVE	06/30/2005	Area Office 7	ORANGE	32803
120004	4369	FLORIDA HOSPITAL-ALTAMONTE	Hospital Prem	ACTIVE	06/30/2005	Area Office 7	SEMINOLE	32701
120003	4369	FLORIDA HOSPITAL-APOPKA	Hospital Prem	ACTIVE	06/30/2005	Area Office 7	ORANGE	32703
23960017	4369	FLORIDA HOSPITAL-CELEBRATION HEALTH	Hospital Prem	ACTIVE	06/30/2005	Area Office 7	OSCEOLA	34747
100021	4369	FLORIDA HOSPITAL-EAST ORLANDO	Hospital Prem	ACTIVE	06/30/2005	Area Office 7	ORANGE	32822
100030	4119	HEALTH CENTRAL	Hospital	ACTIVE	06/30/2005	Area Office 7	ORANGE	34761
100019	4225	HOLMES REGIONAL MEDICAL CENTER	Hospital	ACTIVE	06/30/2005	Area Office 7	BREVARD	32901
100221	4393	LUCERNE MEDICAL CENTER	Hospital Prem	ACTIVE	06/30/2005	Area Office 7	ORANGE	32801
100006	4393	ORLANDO REGIONAL MEDICAL CENTER	Hospital	ACTIVE	06/30/2005	Area Office 7	ORANGE	32806
100110	4450	OSCEOLA REGIONAL MEDICAL CENTER	Hospital	ACTIVE	03/30/2004	Area Office 7	OSCEOLA	34741
120007	4225	PALM BAY COMMUNITY HOSPITAL	Hospital Prem	ACTIVE	06/30/2005	Area Office 7	BREVARD	32907-2599
100028	4467	PARRISH MEDICAL CENTER	Hospital	ACTIVE	11/05/2004	Area Office 7	BREVARD	32796
120002	4393	SAND LAKE HOSPITAL	Hospital Prem	ACTIVE	06/30/2005	Area Office 7	ORANGE	32819
100263	4393	SOUTH SEMINOLE HOSPITAL	Hospital Prem	ACTIVE	06/30/2005	Area Office 7	SEMINOLE	32750
100074	4393	ST CLOUD HOSPITAL	Hospital Prem	ACTIVE	06/30/2005	Area Office 7	OSCEOLA	34769
100162	4369	WINTER PARK MEMORIAL HOSPITAL	Hospital Prem	ACTIVE	06/30/2005	Area Office 7	ORANGE	32792
23960034	4468	WUESTHOFF MEDICAL CENTER - MELBOURNE	Hospital	ACTIVE	11/19/2004	Area Office 7	BREVARD	32935
100092	4132	WUESTHOFF MEDICAL CENTER-ROCKLEDGE	Hospital	ACTIVE	06/30/2005	Area Office 7	BREVARD	32955
100077	4340	BON SECOURS - ST. JOSEPH HOSPITAL	Hospital	ACTIVE	09/30/2003	Area Office 8	CHARLOTTE	33952
100244	4366	CAPE CORAL HOSPITAL	Hospital	ACTIVE	06/30/2004	Area Office 8	LEE	33990
100047	4435	CHARLOTTE REGIONAL MEDICAL CENTER	Hospital	ACTIVE	11/30/2004	Area Office 8	CHARLOTTE	33950
23960025	4463	CLEVELAND CLINIC FLORIDA HOSPITAL-NAPLES	Hospital	ACTIVE	04/01/2005	Area Office 8	COLLIER	34119
111522	4441	GULF COAST HOSPITAL	Hospital	ACTIVE	12/18/2004	Area Office 8	LEE	33912

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lection Criteria: Address type=ST; Modifier Type=S; Modifier=CL01; License status=20

e #	License #	Name	Rank	Status	Expires	Insp Region	County	Zip Code
0005	4186	HEALTHPARK MEDICAL CENTER - LEE MEMORIAL	Hospital Prem	ACTIVE	09/28/2003	Area Office 8	LEE	33908
0012	4186	LEE MEMORIAL HOSPITAL	Hospital	ACTIVE	09/28/2005	Area Office 8	LEE	33901
0018	4113	NAPLES COMMUNITY HOSPITAL	Hospital	ACTIVE	06/30/2005	Area Office 8	COLLIER	33941-3028
0006	4113	NORTH COLLIER HOSPITAL	Hospital Prem	ACTIVE	06/30/2005	Area Office 8	COLLIER	33941-3010
0087	4191	SARASOTA MEMORIAL HOSPITAL	Hospital	ACTIVE	06/30/2005	Area Office 8	SARASOTA	34239
0002	4452	BETHESDA MEMORIAL HOSPITAL	Hospital	ACTIVE	10/30/2004	Area Office 9	PALM BEACH	33435
0168	3983	BOCA RATON COMMUNITY HOSPITAL	Hospital	ACTIVE	06/30/2005	Area Office 9	PALM BEACH	33486
0403	4070	GOOD SAMARITAN MEDICAL CENTER	Hospital	ACTIVE	06/30/2005	Area Office 9	PALM BEACH	33402
0105	4029	INDIAN RIVER MEMORIAL HOSPITAL	Hospital	ACTIVE	04/30/2005	Area Office 9	INDIAN RIV	32960
0253	4072	JUPITER MEDICAL CENTER	Hospital	ACTIVE	06/30/2005	Area Office 9	PALM BEACH	33458
0246	4144	LAWNWOOD REGIONAL MEDICAL CENTER	Hospital	ACTIVE	06/30/2005	Area Office 9	ST. LUCIE	34950-0188
0009	4102	MARTIN MEMORIAL HOSPITAL SOUTH	Hospital Prem	ACTIVE	06/30/2005	Area Office 9	MARTIN	34997
0044	4102	MARTIN MEMORIAL MEDICAL CENTER	Hospital	ACTIVE	06/30/2005	Area Office 9	MARTIN	34995
0176	4127	PALM BEACH GARDENS MEDICAL CENTER	Hospital	ACTIVE	06/30/2005	Area Office 9	PALM BEACH	33410
0006	4164	PALMS WEST HOSPITAL	Hospital	ACTIVE	06/28/2005	Area Office 9	PALM BEACH	33470
0252	4320	RAULERSON HOSPITAL	Hospital	ACTIVE	06/30/2005	Area Office 9	OKEECHOBEE	34972
0260	4193	SAINT LUCIE MEDICAL CENTER	Hospital	ACTIVE	09/19/2003	Area Office 9	ST. LUCIE	34952
0010	4058	SAINT MARYS MEDICAL CENTER	Hospital	ACTIVE	06/30/2005	Area Office 9	PALM BEACH	33407-2495
0217	4375	SEBASTIAN RIVER MEDICAL CENTER	Hospital	ACTIVE	08/21/2004	Area Office 9	INDIAN RIV	32978
0010	4159	WELLINGTON REGIONAL MEDICAL CENTER	Hospital	ACTIVE	09/24/2003	Area Office 9	PALM BEACH	33414
0008	4283	WEST BOCA MEDICAL CENTER	Hospital	ACTIVE	01/31/2004	Area Office 9	PALM BEACH	33428

umber of records selected: 137

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License Lists

Board: 1010 HOSPITAL UNIT
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Selection Criteria: Address type=ST; Modifier Type=S; Modifier=CL00; License status=20

EXCLUDING OB

File #	License #	Name	Rank	Status	Expires	Insp Region	County	Zip Code
110003	4456	GULF BREEZE HOSPITAL	Hospital Prem	ACTIVE	06/30/2005	Area Office 1	SANTA ROSA	32561
100054	4052	TWIN CITIES HOSPITAL	Hospital	ACTIVE	06/30/2005	Area Office 1	OKALOOSA	32578
100056	4299	CLEVELAND CLINIC HOSPITAL	Hospital	ACTIVE	07/01/2005	Area Office 10	BROWARD	33326
100210	4207	FLORIDA MEDICAL CENTER	Hospital	ACTIVE	10/31/2003	Area Office 10	BROWARD	33313-1585
100230	4121	MEMORIAL HOSPITAL PEMBROKE	Hospital	ACTIVE	06/30/2005	Area Office 10	BROWARD	33024
100086	4020	NORTH BROWARD MEDICAL CENTER	Hospital	ACTIVE	06/30/2005	Area Office 10	BROWARD	33064
100237	4139	NORTH RIDGE MEDICAL CENTER	Hospital	ACTIVE	08/31/2005	Area Office 10	BROWARD	33334
100228	4399	WESTSIDE REGIONAL MEDICAL CENTER	Hospital	ACTIVE	11/04/2003	Area Office 10	BROWARD	33324
100131	4430	AVENTURA HOSPITAL AND MEDICAL CENTER	Hospital	ACTIVE	11/04/2003	Area Office 11	DADE	33180
100183	4200	CORAL GABLES HOSPITAL	Hospital	ACTIVE	10/31/2003	Area Office 11	DADE	33134
100020	4288	HEALTHSOUTH DOCTORS' HOSPITAL	Hospital	ACTIVE	02/01/2004	Area Office 11	DADE	33146
100181	4288	LARKIN COMMUNITY HOSPITAL	Hospital	ACTIVE	03/03/2004	Area Office 11	DADE	33143
100060	4066	MOUNT SINAI MEDICAL CENTER AND MIAMI HEA	Hospital Prem	ACTIVE	06/29/2004	Area Office 11	DADE	33140
100050	4065	PALM SPRINGS GENERAL HOSPITAL	Hospital	ACTIVE	06/30/2005	Area Office 11	DADE	33012
100076	4008	PAN AMERICAN HOSPITAL	Hospital	ACTIVE	06/30/2005	Area Office 11	DADE	33126
100071	4217	BROOKSVILLE REGIONAL HOSPITAL	Hospital	ACTIVE	12/27/2003	Area Office 3	HERNANDO	34605-0037
100156	4407	LAKE CITY MEDICAL CENTER	Hospital	ACTIVE	05/16/2005	Area Office 3	COLUMBIA	32055
110183	4006	NORTH FLORIDA RECEPTION CENTER HOSPITAL	Hospital	ACTIVE	06/30/2005	Area Office 3	UNION	32054
100264	4315	OAK HILL HOSPITAL	Hospital	ACTIVE	05/23/2004	Area Office 3	HERNANDO	34606
23960039	4001	WEST MARION COMMUNITY HOSPITAL	Hospital Prem	ACTIVE	09/05/2004	Area Office 3	MARION	34474
100014	4054	BERT FISH MEDICAL CENTER	Hospital	ACTIVE	09/30/2003	Area Office 4	VOLUSIA	32170-1350
100068	4201	FLORIDA HOSPITAL - OCEANSIDE	Hospital Prem	ACTIVE	06/30/2005	Area Office 4	VOLUSIA	32176-8192
100239	4396	EDWARD WHITE HOSPITAL	Hospital	ACTIVE	11/29/2003	Area Office 5	PINELLAS	33733
100248	4398	LARGO MEDICAL CENTER	Hospital	ACTIVE	06/30/2005	Area Office 5	PINELLAS	34649-2905
100238	4324	NORTHSIDE HOSPITAL	Hospital	ACTIVE	02/23/2005	Area Office 5	PINELLAS	33709
100126	4317	PALMS OF PASADENA HOSPITAL	Hospital	ACTIVE	10/14/2005	Area Office 5	PINELLAS	33707
100067	4215	ST ANTHONY'S HOSPITAL	Hospital	ACTIVE	12/31/2003	Area Office 5	PINELLAS	33705
100015	4118	SUN COAST HOSPITAL	Hospital	ACTIVE	06/30/2005	Area Office 5	PINELLAS	34649-2025
100099	4007	LAKE WALES MEDICAL CENTER	Hospital	ACTIVE	11/30/2004	Area Office 6	POLK	33853
100206	4112	MEMORIAL HOSPITAL OF TAMPA	Hospital	ACTIVE	10/14/2003	Area Office 6	HILLSBOROUGH	33609
100259	4198	SOUTH BAY HOSPITAL	Hospital	ACTIVE	09/16/2005	Area Office 6	HILLSBOROUGH	33573

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ard: 1010 HOSPITAL UNIT
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rted by: Inspection region, Name, Status, Licence #
lection Criteria: Address type=ST; Modifier Type=S; Modifier=CL00; License status=20

le #	License #	Name	Rank	Status	Expires	Insp Region	County	Zip Code
10069	4179	UNIVERSITY COMMUNITY HOSPITAL AT CARROLL	Hospital	ACTIVE	10/24/2003	Area Office 6	HILLSBOROUGH	33613
10089	4369	FLORIDA HOSPITAL-KISSIMMEE	Hospital Prem	ACTIVE	06/30/2005	Area Office 7	OSCEOLA	34744
10070	4140	BON SECOURS-VENICE HOSPITAL	Hospital	ACTIVE	08/31/2005	Area Office 8	SARASOTA	34285
10166	4307	DOCTORS HOSPITAL OF SARASOTA	Hospital	ACTIVE	05/31/2004	Area Office 8	SARASOTA	34239
10004	4401	ENGLEWOOD COMMUNITY HOSPITAL	Hospital	ACTIVE	12/17/2003	Area Office 8	SARASOTA	34223
10236	4352	FAWCETT MEMORIAL HOSPITAL	Hospital	ACTIVE	04/29/2005	Area Office 8	CHARLOTTE	33949
10107	4395	LEHIGH REGIONAL MEDICAL CENTER	Hospital	ACTIVE	11/30/2003	Area Office 8	LEE	33936
10220	4301	SOUTHWEST FLORIDA REGIONAL MEDICAL CENTE	Hospital	ACTIVE	06/30/2005	Area Office 8	LEE	33901
10234	4197	COLUMBIA HOSPITAL	Hospital	ACTIVE	06/28/2005	Area Office 9	PALM BEACH	33407
10258	4439	DELRAY MEDICAL CENTER	Hospital	ACTIVE	02/28/2005	Area Office 9	PALM BEACH	33484
10080	4368	JFK MEDICAL CENTER	Hospital	ACTIVE	06/28/2005	Area Office 9	PALM BEACH	33462

lumber of records selected: 42

ATTACHMENT B

Closed Hospitals 2.xls

Lic Nbr	FRAES #	Facility Name	Saddr1	SCity, State	Szip	Full Phone #	Closure Date
			3030 WEST DR. MARTIN L.				
4292	100227	ST. JOSEPH WOMEN'S HOSPITAL	KING JR. BL	TAMPA, FL	33607	(813) 879-4730	19940701
4238	100145	PINELLAS COMMUNITY HOSPITAL	7950 66TH STREET, NORTH	PINELLAS PARK, FL	34665	(727) 545-2580	19960131
4082	100083	RIVERSIDE HOSPITAL - JACKSONVILLE	2033 RIVERSIDE AVENUE	JACKSONVILLE, FL	32204	(904) 387-7000	19960701
4250	100207	PALM BEACH REGIONAL HOSPITAL	2829 TENTH AVENUE NORTH	LAKE WORTH, FL	33461	(407) 967-7800	19971107
4394	100199	POMPANO BEACH MEDICAL CENTER	600 SW 3RD ST	POMPANO BEACH, FL	33060	(954) 782-2000	19971219
		VALUEMARK LAUREL OAKS BEHAVIORAL	6601 CENTRAL FLORIDA				
3976	110015	HEALTHCARE SYSTEM	PARKWAY	ORLANDO, FL	32821	(407) 345-5000	19980710
3956	100144	EVERGLADES REGIONAL MEDICAL CENTER	200 S. BARFIELD HIGHWAY	PAHOKEE, FL	33476	(407) 924-5201	19990323
		CHARTER BEHAVIORAL HEALTH SYSTEM OF					
4287	104014	TAMPA BAY AT LARGO	12891 SEMINOLE BOULEVARD	LARGO, FL	34648	(727) 587-6000	19990625
		CHARTER BEHAVIORAL HEALTH SYSTEM OF					
4287	110056	TAMPA BAY AT PASCO	21808 STATE ROAD 54	LUTZ, FL	33549	(813) 948-2441	19990625
4434	111111	WATEROAK	2634-G CAPITAL CIRCLE, N.E.	TALLAHASSEE, FL	32308	(850) 487-2930	19990630
4386	110011	DORAL PALMS HOSPITAL	11100 N W 27TH STREET	MIAMI, FL	33172	(305) 591-3230	19990903
		CHARTER BEHAVIORAL HEALTH SYSTEM OF					
4287	104012	TAMPA BAY AT TAMPA	4004 N RIVERSIDE DRIVE	TAMPA, FL	33603	(813) 238-8671	20000324
4209	100085	FLORIDA MEDICAL CENTER, SOUTH	5701 W. SUNRISE BLVD	PLANTATION, FL	33313	(954) 581-7800	20000509
4385	104006	HEART OF FLORIDA BEHAVIORAL CENTER	2510 NORTH FLORIDA AVENUE	LAKELAND, FL	33805	(941) 682-6105	20000601
4188	110005	CHARTER SPRINGS HOSPITAL	3130 S.W. 27TH AVENUE	OCALA, FL	34474	(904) 237-7293	20000630
4131	111416	CHARTER GLADE BEHAVIORAL HEALTH SYSTEM	3550 COLONIAL BLVD	FORT MYERS, FL	33912	(800) 274-1230	20000714
4237	110030	PARK PLACE BEHAVIORAL HEALTH CARE		KISSIMMEE, FL	32741	(407) 846-0444	20001130
4063	100170	SHANDS JACKSONVILLE MEDICAL CENTER	580 WEST EIGHTH STREET	JACKSONVILLE, FL	32209	(904) 798-8000	20010326
4181	100229	ATLANTIC MEDICAL CENTER-DAYTONA	400 N. CLYDE MORRIS BLVD.	DAYTONA BEACH, FL	32114	(904) 239-5000	20010723
4016	110483	TACACHALE - DAHLIA HOSPITAL UNIT	1621 N.E. WALDO ROAD	GAINESVILLE, FL	32609	(352) 955-5540	20011105
		MOUNT SINAI MEDICAL CENTER AND MIAMI HEART					
4066	100059	INSTITUTE	250 63RD STREET	MIAMI BEACH, FL	33141	(305) 672-1111	20011206
4168	104005	WINDMOOR HEALTHCARE OF MIAMI	1861 N W SOUTH RIVER DRIVE	MIAMI, FL	33135	(305) 642-3555	20011221
3991	104002	G. PIERCE WOOD MEMORIAL HOSPITAL	5847 SOUTHEAST HIGHWAY 31	ARCADIA, FL	34266	(863) 494-3323	20020228
4157	100261	SUNLAND MARIANNA COX MEDICAL CENTER	3700 WILLIAMS DRIVE	MARIANNA, FL	32446	(850) 482-9484	20020916
4369	110026	WINTER PARK PAVILION	1600 DODD ROAD	WINTER PARK, FL	32792	(407) 677-6842	20030127
0	23960019	CCS BAY COUNTY, INC.	348 MIRACLE STRIP PKWY.	FT. WALTON BEACH, FL	32458		20020309

HOSPITALS WITH ER EXEMPTIONS BY TYPE OF SERVICE EXEMPTED AS OF AUGUST 1, 2003

Winter Haven Hospital **(FO-6)**
Plastic Surgery

Raulerson Hospital **(FO-9)**
Neurosurgery
Orthopedic Surgery
Otolaryngology

Indian River Memorial Hospital **(FO-9)**
Neurosurgery

St. Lucie's Medical Center **(FO-9)**
Neurosurgery
Plastic Surgery
Ophthamology
Oral/Maxillofacial Surgery

Lawnwood Regional Medical Center **(FO-9)**
Neurosurgery
Plastic Surgery
Ophthamology
Oral/Maxillofacial Surgery
Thoracic Surgery
Pediatrics

Parkway Regional Medical Center **(FO-11)**
Plastic Surgery

Hialeah Hospital **(FO-11)**
Otolaryngology

Mariners Hospital **(FO-11)**
Neurosurgery
Ophthalmology
Gastroenterology
Gynecology
Orthopedic Surgery
Otolaryngology
Pediatrics
Pulmonary Medicine
Urological Surgery

Palmetto General Hospital **(FO-11)**
Otolarynology

TOTAL NUMBER OF HOSPITALS WITH ER EXEMPTION BY TYPE OF SERVICE AS OF August 01, 2003

Neurosurgery	(5)
Ophthalmology	(4)
Gastroenterology	(1)
Gynecology	(1)
Orthopedic Surgery	(2)
Thoracic Surgery	(1)
Pediatrics	(2)
Pulmonary Medicine	(1)
Urological Surgery	(1)
PlasticSurgery	(4)
Oral/Maxillofacial Surgery	(2)

With the exemption of Palmetto General Hospital, the deletion of Cardiology at Mariners Hospital and deletion of Orthopedic Surgery at Spring Hill all hospital exemption requests during the last 6 months have been a result of the Agency's requirement that hospitals re-apply for ER exemptions at the time of license renewal.

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

JEB BUSH, GOVERNOR

RHONDA M. MEDOWS, MD, FAAFP, SECRETARY

CERTIFIED
RETURN RECEIPT REQUESTED

December 3, 2002

Mr. Frank Irby
Chief Executive Officer
Raulerson Hospital
1796 Highway 441 North
Okeechobee, FL 34973

Re: Emergency Service Exemptions of Raulerson Hospital

Dear Mr. Irby:

After careful consideration and review of the documentation for emergency service exemptions granted to Raulerson Hospital on May 19, 1994 in the areas of neurosurgery; ear, nose and throat services; and orthopedics; the Agency has determined in accordance with section 395.1041(3), Florida Statutes, that these emergency service exemptions will expire on Raulerson Hospital's current license expiration date of June 30, 2003.

When the hospital renews its license, a re-submission of the service exemption request for each service area must accompany the license application. In addition to the documentation required by the Application for Service Exemption (AHCA Form 3000-1-Jul 93), the following five conditions must also be addressed prior to approval or denial of each service exemption requested:

1. The request for each service exemption must demonstrate what efforts have taken place to recruit physicians in that speciality. The submission shall also include the number of patients presenting, the number of procedures provided, number of patients processed and/or diverted to other hospitals for each service. The exemption request shall conform to subsection 59A-3.207(4)(a)-(f), F.A.C.

2. Should a patient present to the emergency room when the on-call physician for each service is not available, the hospital is responsible to stabilize the patient and make arrangements to transfer the patient to another hospital. Regardless, the hospital will adhere to EMTALA regulations for the disposition of the patient.

3. Notification to EMS of the proposed coverage and what arrangements will be made to handle those patients that present when the physician on call is not available. A copy of this notice shall be provided to the West Palm Beach Field Office Manager.

4. Policies and procedures shall be in place addressing the handling of patients presenting to the emergency room and their disposition.

5. Verification by the West Palm Beach Field Office to determine actual physician on-call coverage for each service exemption will be conducted on a random basis.

Let me assure you that the Agency's primary concern is the availability of emergency services and the quality of care provided to those individuals seeking emergency services in our health care facilities in accordance with state and federal law regarding access to emergency medical care.

If we may be of further assistance, or require additional information, please do not hesitate to contact Ms. Laura MacLafferty, Hospital and Outpatient Services Unit Manager, at (850) 487-2717.

Sincerely,

Elizabeth Dudek

Elizabeth Dudek, Deputy Secretary
Division of Health Quality Assurance

ED/ars

cc: Laura MacLafferty, Hospital & Outpatient Services Unit
Tracey Cottle, Office of the General Counsel
Diane Reiland, West Palm Beach Field Office

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

JEB BUSH, GOVERNOR

RHONDA M. MEDOWS, MD, FAAFP, SECRETARY

CERTIFIED
RETURN RECEIPT REQUESTED

November 5, 2002

Mr. Jeffrey L. Susi
Chief Executive Officer
Indian River Memorial Hospital
1000 36th Street
Vero Beach, FL 32960

Re: Emergency Service Exemption of Indian River Memorial Hospital

Dear Mr. Susi:

After careful consideration and review of the documentation for emergency service exemption granted to Indian River Memorial Hospital on April 24, 1997 in the area of neurosurgery, the Agency has determined in accordance with section 395.1041(3), Florida Statutes, that this emergency service exemption will expire on Indian River Memorial Hospital's current license expiration date of April 30, 2003.

When the hospital renews its license, a re-submission of the service exemption request for each service area must accompany the license application. In addition to the documentation required by the Application for Service Exemption (AHCA Form 3000-1-Jul 93), the following five conditions must also be addressed prior to approval or denial of each service exemption requested:

1. The request for each service exemption must demonstrate what efforts have taken place to recruit physicians in that specialty. The submission shall also include the number of patients presenting, the number of procedures provided, number of patients processed and/or diverted to other hospitals for each service. The exemption request shall conform to subsection 59A-3.207(4)(a)-(f), F.A.C.

2. Should a patient present to the emergency room when the on-call physician for each service is not available, the hospital is responsible to stabilize the patient and make arrangements to transfer the patient to another hospital. Regardless, the hospital will adhere to EMTALA regulations for the disposition of the patient.

3. Notification to EMS of the proposed coverage and what arrangements will be made to handle those patients that present when the physician on call is not available. A copy of this notice shall be provided to the West Palm Beach Field Office Manager.

4. Policies and procedures shall be in place addressing the handling of patients presenting to the emergency room and their disposition.

5. Verification by the West Palm Beach Field Office to determine actual physician on-call coverage for each service exemption will be conducted on a random basis.

Let me assure you that the Agency's primary concern is the availability of emergency services and the quality of care provided to those individuals seeking emergency services in our health care facilities in accordance with state and federal law regarding access to emergency medical care.

If we may be of further assistance, or should you require additional information, please do not hesitate to contact Ms. Laura MacLafferty, Hospital and Outpatient Services Unit Manager, at (850) 487-2717.

Sincerely,

Elizabeth Dudek, Deputy Secretary
Division of Health Quality Assurance

ED/ars

cc: Laura MacLafferty, Hospital & Outpatient Services Unit
Tracy Cottle, Office of the General Counsel
Diane Reiland, West Palm Beach Field Office

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

April 22, 1997

Stephen L. Holmes
Chief Operating Officer
Indian River Memorial Hospital
1000 36th St.
Vero Beach, FL 32960

Dear Mr. Holmes:

This is in response to your new application for service exemption in the area of neurosurgery.

Your application and supporting documents have been reviewed and a determination has been made. It is our decision to continue to grant Indian River Memorial Hospital an exemption from the requirements of section 395.1041(3), Florida Statutes, in the service area of neurosurgery. As your are aware, this section of the law requires every hospital to ensure the provision of services with the service capability of the hospital at all times, unless an exemption has been granted by this Agency. The documentation you submitted has demonstrated to us that your hospital lacks the ability to ensure such capability in the area of neurosurgery and that you have exhausted all reasonable efforts to ensure capability through backup arrangements.

Be advised that if the circumstances in your hospital change so that the information upon which we based our decision is different, you are required to notify us of these changes. We will at that time re-evaluate your request for exemption.

If you have any questions or would like to discuss this in greater detail, please feel free to contact me at (904) 487-2717.

Sincerely,

Daryl R. Barowicz
Health Services Supervisor
Hospital & Outpatient Services
Health Facility Regulation

DB/gs

2727 MAHAN DRIVE • TALLAHASSEE, FLORIDA 32308

STATE OF FLORIDA
AHCA
AGENCY FOR HEALTH CARE ADMINISTRATION

JEB BUSH, GOVERNOR

RHONDA M. MEDOWS, MD, FAAFP, SECRETARY

CERTIFIED MAIL

October 24, 2002

Robert H. Luse, CEO
Mariners Hospital
91500 Overseas Highway
Tavernier, Florida 33070

Dear Mr. Luse:

This is in response to your September 12, 2002 letter requesting an exemption from providing for the following: Cardiology, Gastroenrerology, Gynecology, Neurology, Oncology-Hematology, Opthamology, Orthopedic Surgery, Otolaryngology, Pediatrics, Pulmonary Medicine, Urological Surgery as an emergency service at Mariners Hospital.

Section 395.1041(3) of the law requires every hospital to ensure the provision of services within the service capability of the hospital at all times, unless an exemption has been granted by the Agency.

Section V of the Application for Service Exemption corresponds to the above section of the law. This section requires you to present the facts that would support your hospital has exhausted all reasonable efforts to ensure service capability through backup arrangements. This information was submitted with your request for this service exemption. Your letter indicates that attempts to recruit additional physicians have been unsuccessful. The Agency will grant a service exemption for the provision of Cardiology, Gastroenrerology, Gynecology, Neurology, Oncology-Hematology, Opthamology, Orthopedic Surgery, Otolaryngology, Pediatrics, Pulmonary Medicine, and Urological Surgery emergency services. Your service exemption is granted for two years or your most recent license renewal period. In order to continue these service exemptions please submit an update by February 1, 2005.

The Miami Field Office recently surveyed your facility and during the survey deficiencies were identified. The Miami Field Office will be forwarding these deficiencies to your hospital shortly. The "Statement of Deficiencies and Plan of Correction" (State Form 2567) will list the Deficiencies discussed with you and/or your representatives upon the completion of the survey.

You will need to complete a "Plan of Correction" (PoC) for the deficiencies shown on the "Statement of Deficiencies and Plan of Correction," including the date corrective action was accomplished or is anticipated to be accomplished.

Additionally, I am enclosing Hospital Emergency Services form (AHCA Form 3130-8008). Please fill out this form updating your hospital emergencies services.

If you have any questions or would like to discuss this in greater detail, please feel free to contact Julio González (850) 487-2717.

Sincerely,

Jeffrey N. Gregg, Chief
Bureau of Health Facility Regulations
Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, Florida 32308
(850) 922-0791
gregg@fdhc.state.fl.us

cc: Miami Field Office

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

JEB BUSH, GOVERNOR

RHONDA M. MEDOWS, MD, FAAFP, SECRETARY

October 14, 2002

Mr. Thomas W. Konrad
Rutledge, Ecenia, Purnell & Hoffman
Attorneys and Counselors at Law
215 South Monroe St., Suite 420
Tallahassee, Florida 32301-1841

Re: Request to Amend Settlement Agreement in DOAH Case No. 00-2486, dated June 11, 2001

Dear Mr. Konrad:

Thank you for your letter containing the requested additional information for the emergency plastic surgery service exemption that would amend the settlement agreement in DOAH case no. 00-2486.

After careful consideration and review of the documentation that was provided on behalf of St. Lucie Medical Center, the Agency has determined that the request to amend the Settlement Agreement that would allow for an emergency service exemption for on call coverage plastic surgery for 10 days a month is granted under the following six conditions:

1. This service exemption is granted for this license period expiring on September 19, 2003. When the hospital renews its license, a re-submission of the service exemption request must accompany the license application.

2. The request to continue the service exemption must demonstrate efforts that have taken place to recruit physicians. The submission shall also include the number of patients presenting, the number of plastic surgery procedures provided, and the number of patients processed and/or diverted to other hospitals for plastic surgery services. The exemption request shall conform to subsection 59A-3.207(4)(a)-(f), F.A.C.

3. Should a patient present to the emergency room when the on-call physician is not available, the hospital is responsible for stabilizing the patient and making arrangements to transfer the patient to another hospital. Regardless, the hospital will adhere to EMTALA regulations for the disposition of the patient.

4. Notification to EMS of the proposed coverage and what arrangements will be made to handle those patients who present when the physician on call is not available. A copy of the notice shall be provided to the West Palm Beach Field Office Manager.

5. Policies and procedures shall be in place addressing the handling of patients presenting to the emergency room and their disposition.

6. Verification by the West Palm Beach Field Office to determine actual physician on-call coverage for plastic surgery services will be conducted on a random basis.

Let me also assure you that the Agency's primary concern is for the quality of care provided to individuals seeking emergency services in our health care facilities in accordance with state and federal law regarding access to emergency medical care.

If we may be of further assistance, or if you require additional information, please do not hesitate to contact Ms. Laura MacLafferty, Hospital and Outpatient Services Unit Manager, by telephone at (850) 487-2717.

Sincerely,

Elizabeth Dudek, Deputy Secretary
Division of Managed Care and Health Quality

ED/ars

cc: Laura MacLafferty, HOSU Manager
Tracey Cottle, General Counsel's Office
Diane Reiland, West Palm Beach Field Office Manager

RUTLEDGE, ECENIA, PURNELL & HOFFMAN
PROFESSIONAL ASSOCIATION
ATTORNEYS AND COUNSELORS AT LAW

STEPHEN A. ECENIA
RICHARD M. ELLIS
KENNETH A. HOFFMAN
THOMAS W. KONRAD
MICHAEL G. MAIDA
MARTIN P. McDONNELL
J. STEPHEN MENTON

POST OFFICE BOX 551, 32302-0551
215 SOUTH MONROE STREET, SUITE 420
TALLAHASSEE, FLORIDA 32301-1841

TELEPHONE (850) 681-6788
TELECOPIER (850) 681-6515

R. DAVID PRESCOTT
HAROLD F.X. PURNELL
MARSHA E. RULE
GARY R. RUTLEDGE

GOVERNMENTAL CONSULTANTS
MARGARET A. MENDUNI
M. LANE STEPHENS

October 1, 2002

Via Hand Delivery
Elizabeth Dudek, Deputy Secretary
Division of Managed Care and Health Quality
Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, Florida 32308

RECEIVED
OCT 0 1 2002
Agency for Health Care Administration
Division of Managed Care & Health Quality

RE: St. Lucie Medical Center Service Exemption Request

Dear Ms. Dudek:

This correspondence is in response to your letter dated August 8, 2002, where you requested additional information pertaining to St. Lucie Medical Center's ("St. Lucie") request to amend the Settlement Agreement in DOAH case no. 00-2486, dated June 11, 2001.

St. Lucie responds to your August 8, 2002 correspondence by corresponding paragraph number as follows:

1. The number of occasions from January 1, 2001 through August 31, 2002 where consultation of a plastic surgeon was required in the emergency room was 32 (documentation attached);

2. St. Lucie does not have any transfer agreements with other area hospitals for the provision of emergency plastic surgery services. St. Lucie has a general transfer agreement with Lawnwood Regional Medical Center ("Lawnwood"). However, this agreement does not specify plastic surgery. In this regard, the Agency has granted Lawnwood a service exemption in the area of plastic surgery (attached), among others. The other area hospital, Martin Memorial Medical Center, refuses to enter into a written transfer agreement of any kind with St. Lucie.

3. St. Lucie does not actively recruit board certified plastic surgeons to become members of the medical staff. In order to "recruit" plastic surgeons practicing within its service area, St. Lucie would be required to remunerate such physicians to provide emergency on-call services which is not required by law. St. Lucie will continue to grant staff privileges to physicians who apply to its medical staff in accordance with St. Lucie's medical staff bylaws.

Furthermore, since my earlier August 5, 2002 letter requesting an amendment to the service exemption settlement, the remaining plastic surgeon, Dr. Fasano, has been approved by the medical staff for courtesy privileges at St. Lucie. As such, Dr. Fasano will not be required to provide emergency room coverage. However, a new plastic surgeon has applied for medical staff privileges at St. Lucie and it is anticipated this physician will provide emergency room on call coverage beginning October, 2002.

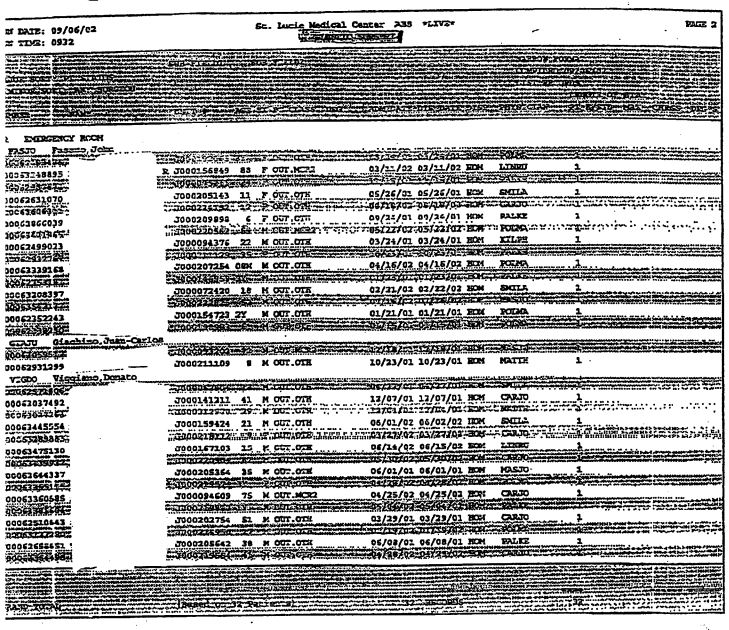
Since St. Lucie will have a single plastic surgeon providing on-call coverage, it is our position that the settlement agreement should be amended to require St. Lucie to provide on call coverage in the area of plastic surgery 10 days a month.

Thank you for your attention to this matter. Please do not hesitate to contact me or Steve Ecenia should you have any question or are in need of additional information.

Sincerely,

Thomas W. Konrad

TWK/tls
F:\USERS\Tammy\St.Lucie\dedekLTR.090602



Time Period 1-1-01 through 8-31-02

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

September 25, 1998

Loren Perona
Lawnwood Regional Medical Center
700 South 23rd St.
P.O. Box 188
Ft. Pierce, FL 34954-0188

JAN 21 1999

Dear Ms. Perona:

This is in response to your application for service exemption in the areas of neurosurgery, ophthalmic services, oral surgery, intensive care services, plastic surgery and thoracic services.

Your application and supporting documents have been reviewed and a determination has been made. It is our decision to grant Lawnwood Regional Medical Center an exemption from the requirements of section 395.1041(3), Florida Statutes, in the service areas of neurosurgery, ophthalmic services, oral surgery, intensive care services, plastic surgery and thoracic services. As you are aware, this section of the law requires every hospital to ensure the provision of services with service capability of the hospital at all times, unless an exemption has been granted by the Agency. The documentation you submitted has demonstrated to us that your hospital lacks the ability to ensure such capability in the areas of neurosurgery, ophthalmic services, oral surgery, intensive care services, plastic surgery and thoracic services, and that you have exhausted all reasonable efforts to ensure capability through backup arrangements.

Be advised that if the circumstances in your hospital change so that the information upon which we based our decision is different, you are required to notify us of these changes. We will at that time re-evaluate your request for exemption.

If you have any questions or would lid to discuss this in greater detail, please feel free to contact me at (850) 487-2717.

Sincerely,

Daryl R. Barowicz
Health Services Supervisor
Hospital & Outpatient Services Unit
Health Facility Compliance

DB/gs

2727 MAHAN DRIVE • TALLAHASSEE, FLORIDA 32308

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

September 25, 1998

Loren Perona
Lawnwood Regional Medical Center
1700 South 23rd St.
P.O. Box 188
Ft. Pierce, FL 34954-0188

Dear Ms. Perona:

This is in response to your application for service exemption in the areas of neurosurgery, ophthalmic services, oral surgery, intensive care services, plastic surgery and thoracic services.

Your application and supporting documents have been reviewed and a determination has been made. It is our decision to grant Lawnwood Regional Medical Center an exemption from the requirements of section 395.1041(3), Florida Statutes, in the service areas of neurosurgery, ophthalmic services, oral surgery, intensive care services, plastic surgery and thoracic services. As you are aware, this section of the law requires every hospital to ensure the provision of services with service capability of the hospital at all times, unless an exemption has been granted by the Agency. The documentation you submitted has demonstrated to us that your hospital lacks the ability to ensure such capability in the areas of neurosurgery, ophthalmic services, oral surgery, intensive care services, plastic surgery and thoracic services, and that you have exhausted all reasonable efforts to ensure capability through backup arrangements.

Be advised that if the circumstances in your hospital change so that the information upon which we based our decision is different, you are required to notify us of these changes. We will at that time re-evaluate your request for exemption.

If you have any questions or would lid to discuss this in greater detail, please feel free to contact me at (850) 487-2717.

Sincerely,

Daryl R. Barowicz
Health Services Supervisor
Hospital & Outpatient Services Unit
Health Facility Compliance

DB/gs

2727 MAHAN DRIVE • TALLAHASSEE, FLORIDA 32308
LAWTON CHILES, GOVERNOR

DRAFT

CERTIFIED
RETURN RECEIPT REQUESTED

October 30, 2002

Mr. Tom Pentz
Chief Executive Officer
Lawnwood Regional Medical Center
1700 South 23rd Street
Fort Pierce, FL 34950-0188

Re: Emergency Service Exemptions of Lawnwood Regional Medical Center

Dear Mr. Pentz:

After careful consideration and review of the documentation for emergency service exemptions granted to Lawnwood Regional Medical Center on September 25, 1998, in the areas of neurosurgery, ophthalmic services, oral surgery, intensive care services, plastic surgery and thoracic surgery, the Agency has determined in accordance with section 395.1041(3), Florida Statutes, that these emergency service exemptions will expire on Lawnwood Regional Medical Center's current license expiration date of June 30, 2003.

When the hospital renews its license, a re-submission of the service exemption request for each service area must accompany the license application. In addition to the documentation required by the Application for Service Exemption (AHCA Form 3000-1-Jul 93), the following five conditions must also be addressed prior to approval or denial of each service exemption requested:

1. The request for each service exemption must demonstrate what efforts have taken place to recruit physicians in that speciality. The submission shall also include the number of patients presenting, the number of procedures provided, number of patients processed and/or diverted to other hospitals for each service. The exemption request shall conform to subsection 59A-3.207(4)(a)-(f), F.A.C.

2. Should a patient present to the emergency room when the on-call physician for each service is not available, the hospital is responsible to stabilize the patient and make arrangements to transfer the patient to another hospital. Regardless, the hospital will adhere to EMTALA regulations for the disposition of the patient.

3. Notification to EMS of the proposed coverage and what arrangements will be made to handle those patients that present when the physician on call is not available. A copy of this notice shall be provided to the West Palm Beach Field Office Manager.

4. Policies and procedures shall be in place addressing the handling of patients presenting to the emergency room and their disposition.

5. Verification by the West Palm Beach Field Office to determine actual physician on-call coverage for each service exemption will be conducted on a random basis.

Let me assure you that the Agency's primary concern is the availability of emergency services and the quality of care provided to those individuals seeking emergency services in our health care facilities in accordance with state and federal law regarding access to emergency medical care.

If we may be of further assistance, or require additional information, please do not hesitate to contact Ms. Laura MacLafferty, Hospital and Outpatient Services Unit Manager, at (850) 487-2717.

Sincerely,

Elizabeth Dudek, Deputy Secretary
Division of Health Quality Assurance

ED/ars

cc: Laura MacLafferty, Hospital & Outpatient Services Unit
Tracy Cottle, Office of the General Counsel
Diane Reiland, West Palm Beach Field Office

DRAFT T 16243 Thomas Konrad
October 10, 2002

Mr. Thomas W. Konrad
Rutledge, Ecenia, Purnell & Hoffman
Attorneys and Counselors at Law
215 South Monroe St., Suite 420
Tallahassee, Florida 32301-1841

Re: Request to Amend Settlement Agreement in DOAH Case No. 00-2486, dated June 11, 2001

Dear Mr. Konrad:

Thank you for your letter containing the requested additional information for the emergency plastic surgery service exemption that would amend the settlement agreement in DOAH case no. 00-2486.

After careful consideration and review of the documentation that was provided on behalf of St. Lucie Medical Center, the Agency has determined that the request to amend the Settlement Agreement that would allow for an emergency service exemption for on call coverage plastic surgery for 10 days a month is granted under the following six conditions:

1. This service exemption is granted for this license period expiring on September 19, 2003. When the hospital renews its license, a re-submission of the service exemption request must accompany the license application.

2. The request to continue the service exemption must demonstrate what efforts have taken place to recruit physicians. The submission shall also include the number of patients presenting, the number of plastic surgery procedures provided, number of patients processed and/or diverted to other hospitals for plastic surgery services. The exemption request shall conform to subsection 59A-3.207(4)(a)-(f), F.A.C.

3. Should a patient present to the emergency room when the on-call physician is not available the hospital is responsible for stabilizing the patient and making arrangements to transfer the patient to another hospital. Regardless, the hospital will adhere to EMTALA regulations for the disposition of the patient.

4. Notification to EMS of the proposed coverage and what arrangements will be made to handle those patients that present when the physician on call is not available. A copy of the notice shall be provided to the West Palm Beach Field Office Manager.

5. Policies and Procedures shall be in place addressing the handling of patients presenting to the emergency room and their disposition

6. Verification by the West Palm Beach Field Office to determine actual physician on-call coverage for plastic surgery services will be conducted on a random basis.

Let me also assure you that the Agency's primary concern is for the quality of care provided to individuals seeking emergency services in our health care facilities in accordance with state and federal law regarding access to emergency medical care.

If we may be of further assistance, or require additional information, please do not hesitate to contact Ms. Laura MacLafferty, Hospital and Outpatient Services Unit Manager, by telephone at (850) 487-2717.

Sincerely,

Elizabeth Dudek, Deputy Secretary
Division of Managed Care and Health Quality

ED/ars

cc: Laura MacLafferty, HOSU Manager
Tracey Cottle, General Counsel's Office
Diane Reiland, West Palm Beach Field Office Manager

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

JEB BUSH, GOVERNOR

RHONDA M. MEDOWS, MD, FAAFP, SECRETARY

CERTIFIED
RETURN RECEIPT REQUESTED

November 5, 2002

Mr. Peter Marmerstein
Chief Executive Officer
Parkway Regional Medical Center
160 N. W. 170th Street
North Miami Beach, FL 33169

Re: Emergency Service Exemption of Parkway Regional Medical Center

Dear Mr. Marmerstein:

After careful consideration and review of the documentation for emergency service exemption granted to Parkway Regional Medical Center on January 25, 1999 in the area of plastic surgery, the Agency has determined in accordance with section 395.1041(3), Florida Statutes, that this emergency service exemption will expire on Parkway Regional Medical Center's current license expiration date of November 12, 2003.

When the hospital renews its license, a re-submission of the service exemption request for each service area must accompany the license application. In addition to the documentation required by the Application for Service Exemption (AHCA Form 3000-1-Jul 93), the following five conditions must also be addressed prior to approval or denial of each service exemption requested:

1. The request for each service exemption must demonstrate what efforts have taken place to recruit physicians in that specialty. The submission shall also include the number of patients presenting, the number of procedures provided, number of patients processed and/or diverted to other hospitals for each service. The exemption request shall conform to subsection 59A-3.207(4)(a)-(f), F.A.C.

2. Should a patient present to the emergency room when the on-call physician for each service is not available, the hospital is responsible to stabilize the patient and make arrangements to transfer the patient to another hospital. Regardless, the hospital will adhere to EMTALA regulations for the disposition of the patient.

3. Notification to EMS of the proposed coverage and what arrangements will be made to handle those patients that present when the physician on call is not available. A copy of this notice shall be provided to the Miami Field Office Manager.

4. Policies and procedures shall be in place addressing the handling of patients presenting to the emergency room and their disposition.

5. Verification by the Miami Field Office to determine actual physician on-call coverage for each service exemption will be conducted on a random basis.

Let me assure you that the Agency's primary concern is the availability of emergency services and the quality of care provided to those individuals seeking emergency services in our health care facilities in accordance with state and federal law regarding access to emergency medical care.

If we may be of further assistance, or should you require additional information, please do not hesitate to contact Ms. Laura MacLafferty, Hospital and Outpatient Services Unit Manager, at (850) 487-2717.

Sincerely,

Elizabeth Dudek, Deputy Secretary
Division of Health Quality Assurance

ED/ars

cc: Laura MacLafferty, Hospital & Outpatient Services Unit
Tracy Cottle, Office of the General Counsel
Diane Castillo, Miami Field Office

FILE COPY

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

JEB BUSH, GOVERNOR

RHONDA M. MEDOWS, MD, FAAFP, SECRETARY

CERTIFIED MAIL

May 28, 2003

Mr. Lance Anastasio
Chief Executive Officer
Winter Haven Hospital
200 Avenue F, NE
Winter Haven, Florida 33881

Re: Emergency Services Exemption (Plastic Surgery)

Dear Mr. Anastasio:

This is in response to your February 17, 2003 letter and application requesting an exemption from providing Plastic Surgery as an emergency service at Winter Haven Hospital.

Section 395.1041(3) Florida Statute, requires every hospital to ensure the provision of services within the service capability of the hospital at all times, unless an exemption has been granted by the Agency.

Section V of the Application for Service Exemption corresponds to the above section of the law. Documentation submitted indicates that all reasonable efforts to provide the service capability have been exhausted.

Based on the review of the information provided, the Agency for Health Care Administration grants a service exemption for providing Plastic Surgery as an emergency service from the date of the request through the licensing cycle which expires on May 19, 2005. Ninety days prior to the license expiration, submission should be made of a request for continuation of the exemption or the facility should be providing the emergency service.

Should you have other questions concerning this matter, please contact Pat Underwood, Health Services & Facilities Consultant, via e-mail at underwop@fdhc.state.fl.us or at (850) 414-6937.

Sincerely,

Laura MacLafferty

Laura MacLafferty, Unit Manager
Hospital and Outpatient Services Unit
Bureau of Health Facility Regulation

cc: Field Office 6

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

JEB BUSH, GOVERNOR

RHONDA M. MEDOWS, MD, FAAFP, SECRETARY

CERTIFIED MAIL

July 17, 2003

Aurelio M. Fernandez, CEO
Hialeah Hospital
651 East 25th Street
Hialeah, Florida 33013

Dear Mr. Fernandez:

This is in response to your July 7, 2003 letter requesting a continuation of your exemption from providing for Otorhinolaryngology as an emergency service at Hialeah Hospital.

Section 395.1041(3) of the law requires every hospital to ensure the provision of services within the service capability of the hospital at all times, unless an exemption has been granted by the Agency.

Section V of the Application for Service Exemption corresponds to the above section of the law. This section requires you to present the facts that would support your hospital has exhausted all reasonable efforts to ensure service capability through backup arrangements. This information was submitted with your request for this service exemption. Your letter indicates that attempts to recruit additional physicians have been unsuccessful. The Agency will grant a service exemption for the provision of Ortorhinolaryngology emergency services. In order to continue this service exemption please submit an update by May 31, 2004.

If you have any questions or would like to discuss this in greater detail, please feel free to contact Julio González (850) 487-2717.

Sincerely,

Laura MacLafferty, Unit Manager
Hospital and Outpatient Services Unit

cc: Miami Field Office

STATE OF FLORIDA
AHCA
AGENCY FOR HEALTH CARE ADMINISTRATION

JEB BUSH, GOVERNOR

RHONDA M. MEDOWS, MD, FAAFP, SECRETARY

CERTIFIED MAIL

July 3, 2003

Robert H. Luse, CEO
Mariners Hospital
91500 Overseas Highway
Tavernier, Florida 33070

Dear Mr. Luse:

This is in response to your May 27, 2003 letter requesting an exemption from providing Cardiology as an emergency service at Mariners Hospital.

Section 395.1041(3) of the law requires every hospital to ensure the provision of services within the service capability of the hospital at all times, unless an exemption has been granted by the Agency.

Section V of the Application for Service Exemption corresponds to the above section of the law. This section requires you to present the facts that would support your hospital has exhausted all reasonable efforts to ensure service capability through backup arrangements. This information was submitted with your request for a service exemption. In the information provided Mariner's Hospital has initiated Routine Transfer Agreements with Baptist Medical Center, South Miami Hospital, and Homestead Hospital. Therefore, it is not necessary for the Agency to grant a service exemption. It will be the responsibility of your hospital to maintain these transfer agreements. Should the transfer end then the hospital will need to request a service exemption.

If you have any questions or would like to discuss this in greater detail, please feel free to contact Julio González (850) 487-2717.

Sincerely,

Laura MacLafferty, Unit Manager
Hospital and Outpatient Services Unit

cc: Miami Field Office

STATE OF FLORIDA
AHCA
AGENCY FOR HEALTH CARE ADMINISTRATION

JEB BUSH, GOVERNOR

RHONDA M. MEDOWS, MD, FAAFP, SECRETARY

CERTIFIED MAIL

October 24, 2002

Robert H. Luse, CEO
Mariners Hospital
91500 Overseas Highway
Tavernier, Florida 33070

Dear Mr. Luse:

This is in response to your September 12, 2002 letter requesting an exemption from providing for the following: Cardiology, Gastroenrerology, Gynecology, Neurology, Oncology-Hematology, Opthamology, Orthopedic Surgery, Otolaryngology, Pediatrics, Pulmonary Medicine, Urological Surgery as an emergency service at Mariners Hospital.

Section 395.1041(3) of the law requires every hospital to ensure the provision of services within the service capability of the hospital at all times, unless an exemption has been granted by the Agency.

Section V of the Application for Service Exemption corresponds to the above section of the law. This section requires you to present the facts that would support your hospital has exhausted all reasonable efforts to ensure service capability through backup arrangements. This information was submitted with your request for this service exemption. Your letter indicates that attempts to recruit additional physicians have been unsuccessful. The Agency will grant a service exemption for the provision of Cardiology, Gastroenrerology, Gynecology, Neurology, Oncology-Hematology, Opthamology, Orthopedic Surgery, Otolaryngology, Pediatrics, Pulmonary Medicine, and Urological Surgery emergency services. Your service exemption is granted for two years or your most recent license renewal period. In order to continue these service exemptions please submit an update by February 1, 2005.

The Miami Field Office recently surveyed your facility and during the survey deficiencies were identified. The Miami Field Office will be forwarding these deficiencies to your hospital shortly. The "Statement of Deficiencies and Plan of Correction" (State Form 2567) will list the Deficiencies discussed with you and/or your representatives upon the completion of the survey.

You will need to complete a "Plan of Correction" (PoC) for the deficiencies shown on the "Statement of Deficiencies and Plan of Correction," including the date corrective action was accomplished or is anticipated to be accomplished.

Additionally, I am enclosing Hospital Emergency Services form (AHCA Form 3130-8008). Please fill out this form updating your hospital emergencies services.

If you have any questions or would like to discuss this in greater detail, please feel free to contact Julio González (850) 487-2717.

Sincerely,

Jeffrey N. Gregg, Chief
Bureau of Health Facility Regulations
Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, Florida 32308
(850) 922-0791
gregg@fdhc.state.fl.us

cc: Miami Field Office

STATE OF FLORIDA
AHCA
AGENCY FOR HEALTH CARE ADMINISTRATION

JEB BUSH, GOVERNOR

RHONDA M. MEDOWS, MD, FAAFP, SECRETARY

May 7, 2003

Certified Mail

Mr. Ralph Aleman, CEO
Palmetto General Hospital
2001 West 68th Street
Hialeah, Florida 33016

Dear Mr. Aleman:

This is in response to your application requesting a service exemption for Otorhinolaryngology (ENT) at Palmetto General Hospital. Your application has been reviewed, however, additional information is needed to assist in making a determination whether to grant this exemption. Included in your application are phone contacts that list the responses from local area hospitals within a 50-mile radius regarding the acceptance of these patient transfers. Written responses from these facilities indicating their willingness to accept or not accept transfers were not included with the application. In order to continue with your request, the Agency will need to review these written responses. Additionally, please submit documentation that would confirm the current listed ENT physicians are on hospital's medical staff, their medical staff credentials and a copy of the hospital by-laws that indicate when a physician is exempt from emergency services call.

Section 395.1041(3), Florida Statutes requires every hospital to ensure the provision of services within the service capability of the hospital at all times, unless an exemption has been granted by the Agency. The documentation you submitted does not indicate that all reasonable efforts to ensure capability through backup arrangements have been pursued.

Should you have any additional questions you may contact Julio González, Health Services and Facilities Consultant, at (850) 487-2717.

Sincerely,

Laura MacLafferty, Unit Manager
Hospital and Outpatient Services Unit

ATTACHMENT C

New Beds

Facility	Type Beds	# of Beds	Licensed/ Approved	District
All Children's Hospital	NICU II	11	A	5
All Children's Hospital	NICU III	13	A	5
Arnold Palmer	Acute	116	A	7
Aventura Hospital	Adult Psych	20	A	11
Baptist Beaches	Acute	10	A	4
Baptist Hospital of Miami	Acute	38	L	11
Baptist Hospital of Miami	NICU II	10	A	11
Baptist Hospital of Miami	Acute	16	A	11
Baptist Medical Center - Beaches	Acute	8	L	4
Bay Medical Center	Adult Psych	10	A	1
Bethesda Healthcare System	Acute	80	A	9
Bethesda Healthcare System	CMR	28	A	9
Boca Raton Community Hospital	NICU II	10	L	9
Brandon Regional Hospital	Acute	22	L	6
Brandon Regional Hospital	Acute	50	A	6
Brandon Regional Hospital	Acute	50	A	6
Brooks Rehabilitation	CMR	16	A	4
Brooksville Regional	Acute	91	A	3
Cleveland Clinic Florida Hospital - Naples	Acute	70	L	8
Collier HMA	Acute	100	A	8
Community Hospital	Adult Psych	10	L	5
Community Hospital	Acute	345	A	5
Community Hospital	Adult Psych	56	A	5
Delray Medical Center	Acute	42	L	9
Delray Medical Center	Acute	29	L	9
Doctors Hospital of Sarasota	Acute	21	L	8
Doctor's Memorial Perry	Acute	48	A	2

July 25, 2003 CON Program: New Hospital Beds Either Licensed Since 2000 or Approved Since 2000

New Beds

Facility	Type Beds	# of Beds	Licensed/ Approved	District
East Pasco Medical Center	Adult Psych	15	L	5
Flagler Hospital	Acute	31	L	4
Florida Hospital - Celebration Health	Acute	40	L	7
Florida Hospital - East Orlando	Acute	11	L	7
Florida Hospital - East Orlando	Acute	12	L	7
Florida Hospital - Kisssimmee	Acute	10	L	7
Florida Hospital Fish Memorial	Acute	42	A	4
Florida Hospital Heartland Medical Ctr.	Acute	10	L	6
Florida Hospital Orlando	NICU III	20	A	7
Florida Hospital Oviedo	Acute	60	A	7
Health Central	Acute	30	L	7
HealthSouth Emerald Coast	CMR	25	L	2
Healthsouth Emerald Coast Rehab	CMR	10	A	2
Healthsouth LTAC of Sarasota	LTC	40	A	8
HealthSouth of Sarasota	CMR	7	A	8
Healthsouth Rehab Hosp. of Spring Hill	CMR	60	L	3
HealthSouth Rehab Hospital	CMR	4	L	5
HealthSouth Rehab Hospital	CMR	6	L	5
Healthsouth Rehab Hospital of Sarasota	CMR	5	L	8
Healthsouth Rehab Hospital of Sarasota	CMR	1	L	8
Healthsouth Rehab Hospital of Tallahassee	CMR	6	L	2
Healthsouth Rehabilitation Hospital	CMR	15	L	11
Healthsouth Rehabilitation Hospital	CMR	20	A	5
HealthSouth Sea Pines Rehab Hospital	CMR	10	L	7
Healthsouth Sunrise Rehab Hospital	CMR	10	L	10
HealthSouth Treasure Coast	CMR	13	A	9
Heart of Florida Regional Medical Center	Acute	40	L	6
Hollywood MC	CMR	5	A	10

July 25, 2003 CON Program: New Hospital Beds Either Licensed Since 2000 or Approved Since 2000

New Beds

Facility	Type Beds	# of Beds	Licensed/ Approved	District
Holmes Regional Medical Center	Acute	41	L	7
Homestead Hospital	Acute	120	A	11
Jackson Memorial Hospital	NICU II	5	A	11
JFK Medical Center	Acute	24	L	9
JFK Medical Center	Acute	73	A	9
Kendall HealthCare Group	Acute	80	A	11
Kendall MC	Acute	10	A	11
Kindred Hospital - Bay Area - St. Petersburg	LTC	22	L	5
Kindred Hospital - Ft. Lauderdale	LTC	6	A	10
Kindred Hospital North Florida	LTC	20	A	4
Kindred North Florida	LTC	20	A	4
Lake City Medical Center	Acute	12	L	3
LakeSide Alternatives	Adult Psych	32	A	7
Larkin Community Hospital	Adult Psych	10	L	11
Larkin Community Hospital	Adult Psych	8	A	11
Lawnwood RMC	CMR	8	A	9
Lee Memorial Hospital - Healthpark	Acute	18	L	8
Lee Memorial Hospital - Healthpark	NICU III	2	A	8
Lee Memorial Hospital - Healthpark	Acute	122	A	8
Leesburg Regional	Acute	41	A	3
Leesburg Regional	Acute	15	A	3
Marion Citrus Mental Health	Adult Psych	15	A	3
Mease Hospital	Acute	45	L	5
Memorial Hospital - West	NICU II	10	L	10
Memorial Hospital - West	Acute	36	L	10
Memorial Hospital - West	Acute	16	L	10
Memorial Regional Hospital	NICU II	12	L	10
Memorial Regional Hospital	CMR	6	A	10

July 25, 2003 CON Program: New Hospital Beds Either Licensed Since 2000 or Approved Since 2000

New Beds

Facility	Type Beds	# of Beds	Licensed/ Approved	District
Mt. Sinai MC & Miami Heart	CMR	60	A	11
Munroe RMC	Acute	23	A	3
Naples Community Hospital	CMR	18	L	8
Naples Community Hospital	CMR	12	L	8
North Bay Hospital	Acute	102	A	5
North Bay Hospital	CMR	20	A	5
North Collier Hospital	Acute	10	L	8
North Collier Hospital	NICU II	9	L	8
North Collier Hospital	Acute	10	L	8
North Collier Hospital	Acute	11	A	8
North Florida Regional Medical Center	Acute	44	A	3
Northwest Medical Center	Acute	25	L	10
Northwest Medical Center	Acute	40	A	10
Orange Park	Acute	11	A	4
Orlando RMC	NICU II	34	A	7
Orlando RMC	Acute	64	A	7
Osceola RMC	Acute	40	A	7
Palmetto General Hospital	Adult Psych	16	L	11
Palms West Hospital	Acute	23	L	9
Palms West Hospital	Acute	35	A	9
Regional Medical Center Bayonet Point	Acute	34	L	5
Sacred Heart Hospital	Acute	36	A	1
Sacred Heart Hospital	NICU III	4	A	1
Sacred Heart Hospital on the Emerald Coast	Acute	50	L	1
SandyPines	IRTF	4	L	9
SandyPines	IRTF	10	L	9
Savannas Hospital	CA Psych	5	L	9
Select Specialty Hospital - Miami	LTC	40	L	11

July 25, 2003 CON Program: New Hospital Beds Either Licensed Since 2000 or Approved Since 2000

New Beds

Facility	Type Beds	# of Beds	Licensed/ Approved	District
Sempercare Hospital of Panama City	LTC	30	A	2
Sempercare Hospital of Tallahssee, Inc.	LTC	29	A	2
Sempercare of Orlando	LTC	35	A	7
Seven Rivers Community Hosp	CMR	8	A	3
Shands at U of F	Acute	48	A	3
Shands Hospital at the University of Florida	Acute	24	L	3
South Broward Hospital District	Acute	100	A	10
Southern Baptist Hosp. of FL	Acute	92	A	4
Southern Winds Hospital	Adult Psych	12	L	11
St. John's Rehabilitation Hospital	CMR	6	A	10
St. Joseph's Hospital	Acute	76	A	6
St. Lucie Medical Center	Acute	20	L	9
St. Lucie Medical Center	Acute	44	L	9
St. Luke's MC	Acute	214	A	4
St. Vincent's Medical Center	NICU II	10	A	4
St. Vincent's Medical Center	Acute	135	A	4
The Villages Regional Hospital	Acute	60	L	3
University Behavioral Center	IRTF	20	L	7
University Hospital & MC	Adult Psych	10	A	10
Wellington Regional Medical Center	NICU II	4	L	9
Wellington Regional Medical Center	NICU II	2	A	9
Wellington Regional Medical Center	Acute	7	A	9
West Kendall Baptist Hospital	Acute	80	A	11
West Marion Community Hospital	Acute	70	L	3
Westside RMC	Acute	20	A	10
Wuesthoff Medical Center - Melbourne	Acute	50	L	7
Wuesthoff Medical Center - Melbourne	Acute	15	L	7

July 25, 2003 CON Program: Hospital Beds Reclassified and Either Licensed Since 2000 or Approved Since 2000

Reclassified Beds

Facility Name	Converted From	Converted To	# of Beds	Licensed/ Approved	District
Baptist Medical Center - Beaches	Adult Psyche	Acute	38	L	4
Bethesda Memorial Hospital	Acute	NICU III	3	L	9
Bethesda Memorial Hospital	SNU	Acute	27	L	9
Bethesda Memorial Hospital	Adult Psyche	Acute	20	L	9
Blake Medical Center	SNU	Acute	28	L	6
Brandon Regional Hospital	Acute	NICU II	4	L	6
Brandon Regional Hospital	Acute	NICU III	3	L	6
Brandon Regional Hospital	SNU	Acute	15	L	6
Broward General Medical Center	SNU	Acute	20	L	10
Cedars Medical Center	Acute	Adult Psyche	32	L	11
Cedars Medical Center	SNU	Acute	25	L	11
Charlotte RMC	Adult SA	Adult Psyche	10	A	8
Community Hospital of New Port Richey	SNU	Acute	23	L	5
East Pasco Medical Center	SNU	Acute	12	L	5
Edward White Hospital	SNU	Acute	10	L	5
Englewood Community Hospital	SNU	Acute	10	L	8
Fawcett Memorial Hospital	SNU	Acute	25	L	8
Florida Hospital - Altamonte	SNU	Acute	17	L	7
Florida Hospital - Orlando	Adult Psyche	Acute	20	L	7
Florida Hospital - Orlando	SNU	Acute	35	A	7
Florida Hospital - Waterman	SNU	Acute	29	L	3
Florida Hospital - Wauchula	SNU	Acute	20	L	6
Florida Hospital - Winter Park	SNU	CMR	19	L	7
Florida Hospital - Winter Park	Acute	CMR	1	L	7
Florida Hospital Waterman	SNU	Acute	20	L	3
Fort Walton Beach Medical Center	SNU	Acute	18	L	1

July 25, 2003 CON Program: Hospital Beds Reclassified and Either Licensed Since 2000 or Approved Since 2000

Reclassified Beds

Facility Name	Converted From	Converted To	# of Beds	Licensed/ Approved	District
Gulf Coast Medical Center	SNU	Acute	11	L	2
Halifax Medical Center	SNU	Acute	28	L	4
HealthSouth Doctors	SNU	Acute	30	A	11
Holmes Regional Medical Center	SNU	Acute	30	L	7
Holy Cross Hospital	SNU	Acute	24	L	10
Indian River Memorial Hospital	SNU	Acute	8	L	9
JFK Medical Center	SNU	Acute	20	L	9
Kendall MC	Acute	Adult Psych	20	A	11
Lake City Medical Center	SNU	Acute	5	L	3
Largo Medical Center	SNU	Acute	13	L	5
Lawnwood Regional Medical Center	SNU	Acute	33	L	9
Lehigh Regional Medical Center	SNU	Acute	13	L	8
Memorial Hospital - Flagler	SNU	Acute	8	L	4
Memorial Hospital - Ormond Beach	SNU	Acute	17	L	4
Memorial Regional MC	Adult Psych	Acute	26	A	10
Memorial Regional MC	Adult Psych	Child Psych	4	A	10
Mercy Medical Development, Inc.	Acute	LTC	29	L	11
Mt. Sinai Medical Center	Acute	NICU III	5	L	11
Naples Community Hospital	SNU	Acute	24	L	8
North Broward Medical Center	SNU	Acute	18	L	10
North Broward Medical Center	SNU	Acute	18	A	10
North Florida Regional Medical Center	SNU	Acute	24	L	3
North Shore Medical Center	Acute	NICU II	7	A	11
North Shore Medical Center	Acute	NICU III	2	A	11
North Shore Medical Center	Acute	Adult Psych	2	A	11
North Shore Medical Center	Acute	NICU II	7	A	11
Northwest Medical Center	SNU	Acute	13	L	10

July 25, 2003 CON Program: Hospital Beds Reclassified and Either Licensed Since 2000 or Approved Since 2000

Reclassified Beds

Facility Name	Converted From	Converted To	# of Beds	Licensed/ Approved	District
Northwest Medical Center	SNU	Acute	13	A	10
Orange Park MC	SNU	Acute	16	A	4
Orlando Regional Medical Center	SNU	Acute	29	L	7
Palmetto General Hospital	Acute	NICU II	5	A	11
Parkway Regional Medical Center	SNU	Acute	22	L	11
Pasco Regional Medical Center	SNU	Acute	16	L	5
Plantation General Hospital	Acute	Adult Sub Abuse	16	L	10
Raulerson Hospital	SNU	Acute	12	L	9
Regional Medical Center Bayonet Point	SNU	Acute	12	L	5
Sand Lake Hospital	Adult Psych	Acute	32	L	7
Savannas Hospital	Adult Sub Abuse	Adult Psyche	5	L	9
Savannas Hospital	CA Psyche	Adult Psyche	5	L	9
Seven Rivers Community Hospital	Adult Psych	CMR	8	A	3
Shands Jacksonville MC	Adult Psych	SNU	13	A	4
South Bay Hospital	SNU	Acute	11	L	6
South Miami Hospital	Acute	SNU	12	L	11
South Miami Hospital	SNU	Acute	32	L	11
Southwest Florida Regional Med Ctr.	SNU	Acute	20	L	8
St. Joseph Hospital of Port Charlotte	Acute	SNU	10	L	8
St. Joseph's Hospital	SNU	Acute	29	A	6
St. Lukes Hospital	SNU	NICU II	10	L	4
St. Lukes Hospital	SNU	Acute	7	L	4
St. Mary's MC	Acute	NICU III	10	A	9
St. Petersburg General Hospital	SNU	Acute	20	L	5
St. Vincent's Medical Center	Adult Psych	Acute	21	L	4
St. Vincent's Medical Center	SNU	Acute	34	L	4
Tallahassee Community Hospital	Child SA	Acute	20	A	2

Reclassified Beds

Facility Name	Converted From	Converted To	# of Beds	Licensed/ Approved	District
University Community - carrollwood	SNU	Acute	8	A	6
University Community Hospital	SNU	Acute	7	L	6
University Community Hospital	Acute	NICU III	5	A	6
University Hospital and Medical Center	SNU	Acute	28	L	10
West Boca Medical Center	Acute	NICU III	4	L	9
West Boca Medical Center	Acute	NICU II	6	L	9
West Florida Hospital	SNU	Acute	40	L	1
Winter Haven Hospital	SNU	Acute	100	L	6
Winter Park Memorial Hospital	Adult Psyche	Acute	15	L	7
Winter Park Memorial Hospital	SNU	Acute	19	L	7

Delicensed Beds

Facility	Type Beds	# of Beds	Delicensed/ Approved	District
Florida Hospital - Wauchula	Acute	-19	D	6
University Behavioral Center	Psych - Adult	-28	D	7
Naples Community Hospital	Acute	-18	D	8
Deering Hospital	CA Psych	-6	D	11
Shands at Lake Shore	Acute	-29	D	3
Atlantic Medical Center - Daytona	Adult Sub Abuse	-25	D	4
Manatee Memorial Hospital	SNU	-10	D	6
Jacksonville Memorial Hospital North	NICU II	-9	D	11
South Miami Hospital	Acute	-55	D	11
Baptist Medical Center	Acute	-8	D	4
Lakeside Alternatives	Acute	-126	D	7
Fawcett Memorial Hospital	Acute	-3	D	8
Lake Butler Hospital and Hand Surgery Ctr	Acute	-2	D	3
Community Hospital	Acute	-23	D	5
Mease Hospital - Dunedin	Acute	-45	D	5
Winter Haven Hospital	CA Psych	-30	D	6
Manatee Memorial Hospital	Adult Sub Abuse	-11	D	6
Lawnwood Regional Medical Center	Acute	-20	D	9
Wellington Regional Medical Center	Adult Sub Abuse	-16	D	9
North Ridge Medical Center	Acute	-63	D	10
Healthsouth Doctors Hospital	Acute	-4	D	11
Doctor's Memorial Hospital - Bonifay	Acute	-9	D	2
Ocala Regional Medical Center	Acute	-10	D	3
Ocala Regional Medical Center	SNU	-20	D	3
Sarasota Memorial Hospital	Acute	-17	D	8
Windmoor Healthcare of Clearwater	Adult Psych	-63	D	5
Florida Hospital - Orlando	CMR	-20	D	7

Delicensed Beds

Facility	Type Beds	# of Beds	Delicensed/ Approved	District
Florida Hospital - Altamonte	Adult Psych	-20	D	7
Winter Park Pavillion	Adult Psych	-24	D	7
Winter Park Pavillion	Adult Sub Abuse	-13	D	7
Bon Secours - Venice Hospital	Adult Psych	-30	D	8
Coral Gables Hospital	Acute	-17	D	11
Mt. Sinai Medical Center	Adult Sub Abuse	-24	D	11
Doral Palms Hospital	Adult Psych	-54	D	11
Doral Palms Hospital	CA Psych	-26	D	11
Doral Palms Hospital	Adult Sub Abuse	-8	D	11
Windmoor Healthcare of Miami	Adult Psych	-74	D	11
Mt. Sinai Med Ctr & Miami Heart Inst. (north)	Adult Psych	-20	D	11
Clearwater Community Hospital	Acute	-113	D	5
Clearwater Community Hospital	SNU	-20	D	5
Charter Springs - Ocala	Adult Psych	-32	D	3
Charter Springs - Ocala	CA Psych	-40	D	3
Heart of Florida Behavioral Center	Adult Psych	-32	D	6
Heart of Florida Behavioral Center	CA Psych	-18	D	6
Heart of Florida Behavioral Center	Adult Sub Abuse	-16	D	6
Park Place Behavioral Health Care	Adult Psych	-36	D	7
Park Place Behavioral Health Care	CA Psych	-10	D	7
Park Place Behavioral Health Care	Adult Sub Abuse	-14	D	7
Charter Glade Behavioral Health System	Adult Psych	-96	D	8
Charter Glade Behavioral Health System	CA Psych	-24	D	8
Charter Glade Behavioral Health System	Adult Sub Abuse	-24	D	8
Bethesda Healthcare System	Acute	-80	D	9
Jackson Memorial Hospital	NICU II	-5	A	11
West Kendall Baptist Hospital	Acute	-80	A	11
Kendall HealthCare Group	Acute	-80	A	11

Delicensed Beds

Facility	Type Beds	# of Beds	Delicensed/ Approved	District
Bayfront Medical Center	NICU II	-22	A	5
Lucerne	Acute	-116	A	7
North West Florida Community Hosp	Acute	-34	A	2
Brooksville Regional	Acute	-91	A	3
Leesburg Regional North	Acute	-41	A	3
Doctor's Memorial - Perry	Acute	-48	A	2
Shands Jacksonville	Acute	-64	A	4
St. Luke's Hospital	NICU II	-10	A	4
St. Luke's Hospital	Acute	-279	A	4
St. Vincent's MC	Acute	-70	A	4
Baptist Medical Center	Acute	-92	A	4
North Bay Hospital	Acute	-102	A	5
North Bay Hospital	CMR	-20	A	5
Community Hospital	Acute	-347	A	5
Community Hospital	Adult Psych	-56	A	5
St. Anthony's Hospital	Acute	-10	A	5
St. Joseph's Hospital	Acute	-76	A	6
Florida Hospital Apopka	Acute	-10	A	7
Winter Park Hospital	Acute	-50	A	7
Hendry RMC	Acute	-41	A	8
Lee Memorial Cleveland	Acute	-81	A	8
Cape Coral Hospital	Acute	-41	A	8
Good Samaritan MC	NICU III	-8	A	9
Bethesda Healthcare System	Acute	-80	A	9
University Hospital & MC	Child Psych	-16	A	10
Aventura Hospital MC	Adult SA	-24	A	11
Kendal MC	Acute	-80	A	11
Mt. Sinai MC	CMR	-60	A	11

July 25, 2003 CON Program: Hospital Beds Either Delicensed Since 2000 or Approved to be Delicensed Since 2000

Delicensed Beds

Facility	Type Beds	# of Beds	Delicensed/ Approved	District
Homestead Hospital	Acute	-120	A	11
South Miami Hospital	Acute	-80	A	11
Memorial Hospital - Ormond Beach	SNU	-1	A	4
Flagler Hospital	Adult Psyche	-17	L	4

FPIC

Insurance Solutions for Healthcare Providers

August 15, 2003

Robert E. White, Jr.
President

Via Overnight Delivery

Senator Alex Villalobos
The Florida Senate
Committee on Judiciary
515 Knott Building
404 South Monroe Street
Tallahassee, Florida 32399-1100

Re: Response to Your Letter Dated July 29, 2003

Dear Senator Villalobos:

This letter is in response to your July 29, 2003 letter requesting additional information related to my testimony to the Senate Committee on Judiciary.

1. *Please provide the number of claims per 100 insured physicians for each year from 1996 through 2002.*

The following table illustrates the number of claims per 100 insured physicians:

First Professionals Insurance Company
Physicians & Surgeons Professional Liability
Florida Only
As of 06/30/2003
Number of Claims per 100 Exposures Insured

Report Year	Number of Claims Per 100 Doctors
1996	8.1
1997	8.8
1998	9.0
1999	8.5
2000	9.7
2001	10.9
2002	11.6

1000 Riverside Avenue, Suite 800 • Jacksonville, FL 32204 • (904) 354-5910 • 1-800-741-3742 • Fax (904) 350-1009
Mailing address: P.O. Box 44033 • Jacksonville, FL 32231-4033
Internet Address: http://www.fpic.com

Large

THE FLORIDA SENATE

COMMITTEE ON JUDICIARY

Location
515 Knott Building

Mailing Address
404 South Monroe Street
Tallahassee, Florida 32399-1100
(850) 487-5198

J. Alex Villalobos, *Chair*
Dave Aronberg, *Vice Chair*
Dawn Roberts, *Staff Director*
Senate's Website: *www.flsenate.gov*

July 29, 2003

William Large
General Counsel, Florida Dept. of Health
4052 Bald Cypress Way, Bin A02
Tallahassee, Florida 32399-1703

Dear Mr. Large:

In reviewing the transcript of the Senate Committee on Judiciary meeting on July 14-15, 2003, we have identified several occurrences where you were asked to provide information subsequent to your testimony. Additionally, the committee has identified certain issues for which it requests additional information. Specifically, we request a response in the following instances:

1. Who provided language to the task force regarding setoffs?
2. How many votes were taken by the task force relating to caps? Why was more than one vote taken on this issue? Please explain the purpose of each vote. Please provide the vote count of each vote, and indicate who voted in the affirmative and the negative on each vote.

We ask that you please provide the appropriate responsive documentation to the Senate Committee on Judiciary no later than **5:00 pm on Monday, August 4, 2003**. To aid you in your response, we have attached those pages of the transcript that contain your testimony. If you have any questions, please contact Judiciary Committee staff at (850) 487-5198.

Sincerely,

Senator Alex Villalobos
Chair

Jeb Bush
Governor

FLORIDA DEPARTMENT OF HEALTH

John O. Agwunobi, M.D., M.B.A.
Secretary

August 4, 2003

The Honorable Alex Villalobos
The Florida Senate
404 South Monroe Street
Tallahassee, FL. 32399-1100

Dear Senator Villalobos:

I am in receipt of your letter of July 29th, 2003 asking for additional information. As you will no doubt recall, you asked that I respond to two queries (it should be noted that your second question has several subparts; and, accordingly, I will address this latter query in subparts). The following are my responses.

1. Who provided language to the task force regarding setoffs?

ANSWER: Jennings "Bucky" Hurt; Gail Parienti; Jeff Scott and Mark Delegal. Additionally, pursuant to a public records request, a draft of the set off language was shared with Attorney George Meros. During a phone conversation, Mr. Meros offered comments and criticisms, which were also incorporated.

2. How many votes were taken by the task force relating to caps? Why was more than one vote taken on this issue? Please explain the purpose of each vote. Please provide the vote count of each vote, and indicate who voted in the affirmative and the negative on each vote.

a) How many votes were taken by the task force relating to caps?

ANSWER: Four

b) Why was more than one vote taken on this issue?; c) Please explain the purpose of each vote.

ANSWER: It is impossible to answer this question without specifically citing the text of the transcripts of each vote. In order to supplement my response, I have below a verbatim transcript incorporated within the text of this document. Moreover, I have subdivided my responses for subparts b) and c) into the days that a vote or discussion was had regarding the cap on non-economic damages.

DECEMBER 20th, 2002

As can be seen below, the purpose of the December 20, 2002 meeting was to cull down the myriad of issues that were placed before the taskforce. This was accomplished in the following format: a yes vote simply meant that an issue was worthy of pursuing further. By pursuing further, it was meant that the task force was instructing me to present some type of written proposal in the future. This was not meant to be a final vote. It simply was a vote to have me write up a proposal for continued review. Please note my instructions: **[Page 179, line 1]** "Now the way I see the task force working today is really trying to cull the issues down. The task force, if they voted down an issue and said no, this is not an issue we want to pursue, I would see that being the end of the possibility of that issue being part of our report. If the task force voted yes for an issue, that's really the first step. What that is is [an] instruction to me to go back and write up a proposal. And in January....we would bring up these issues again...So it is possible today for you to vote for something that you might not be sure about, **[Page 180]** and in January, I might present to you a written product that you at that point might vote down.

Thus, as is exhibited below, the purpose and reason of the December 20th, 2002 vote was for me to write up a proposal for the Task Force to review. As Dr. Hitt noted, **[Page 256, line 20]**, "I would like to see your best effort at justifying a cap on non-economic damages under the constitutional test as you enumerated it, and I think that we almost have to do that."

December 20, 2002

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MR. HITT: Thank you sir. We are going to move now to the delivery phase of our process, and I will ask Mr. Large to give us some comments as we move into that.

First off, I think we are going to comment on some criteria that you are suggesting for us. I will leave your comments pretty much to you as to how you pursue them.

MR. LARGE: Mr. Chairman, what I have done is based upon several of the phone calls that are publicly noticed phone call meetings we had. One of the things I received instruction from the task force to do was to, number one, outline all the issues that we had heard in our previous meetings.

Number two, reevaluate and set out again the Governor's Charge to the task force.

And number three, develop a set of criteria with each specific recommendation would be judged by.

So with that charge, what I have done is on page 2, I have set out the Governor's Charge

Page 175

to the task force. On page 3, I developed four questions. And those four questions I think can be used as a criteria to judge each specific recommendation.

Those are on page 3 and those questions Roman Number I through IV. The task force in reviewing its recommendation may decide that a particular proposal needs to have all four components of these questions answered or the task force might believe that only one or two of those components need to be answered.

I don't mean this to be a line in the sand, but this, I think, is a good guide to judge each issue by.

From there beginning on page 4, I have set out all the issues that were raised before the task force, and I have put it under the umbrella of five separate headings.

Tort reform, which is on pages 4 through 7; alternative dispute resolutions, which is on pages 7 through 8; health care quality issues, which is on page 8; physician discipline, which is on pages 8 through 9; and insurance reform, which is on pages 9 through 10.

And then under each one of those large

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developed and then we will judge each specific criteria by that.

The first question under Roman Number I is: Will the proposed change improve access to specialists or critical care providers or medical facilities for emergency care, obstetrical services, neurological services or surgery?

Roman II is: Will the proposed change facilitate the availability of malpractice insurance or other means for injured parties to recover reasonable compensation for injuries caused by the negligent acts of health care providers?

Roman Numeral III is: Will the proposed

change facilitate identifying and addressing health care provider problems as soon as possible to reduce or eliminate the risk to patients?

And Roman Numeral IV is: Will the proposed change assist in reducing or holding down the cost of medical care to citizens and citizen's health insurance providers to facilitate access to health care.

Does the task force find those four

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questions sufficient? Is there another question the task force would want to utilize to judge each specific criteria?

MR. BEARD: It looks sufficient to me, but it doesn't mean we have to qualify all four for one' issue; it means that any of these, of the four would be --

MR. LARGE: That's correct.

MR. HITT: But the more the merrier.

MR. LARGE: I can see the task force, if one option had all four, yes; three, yes; two, that could be a maybe; but one still is within discretion of the task force.

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Now the way I see the task force working today is really trying to cull the issues down. The task force, if they voted down an issue and said no, this is not an issue we want to pursue, I would see that being the end of the possibility of that issue being part of our report.

If the task force voted yes for an issue, that's really only the first step. What that is is instruction to me to go back and write up a proposal. And in January, either our January 16th meeting or at our regularly noticed phone meetings, we would bring up these issues again.

So, for example, the patient safety and the patient safety center issue. If you all voted no on that, that would be the end of the

road. If you voted yes on that and then also the subissues under it, what you are doing is you are giving me an instruction, William and staff, this is something we want to pursue, go back and draft something up, and we want to take a look at your final work product.

So it is possible today for you to vote for something that you might not be sure about,

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and in January, I might present to you a written product that you at that point might vote down.

So, for example, not necessarily the physician quality issues or health care quality issues, but some of the tort reform issues, there is a lot of constitutional concerns out there. And you may want to see a constitutional analysis in detail in January. So that's how I anticipate this working.

Page 255

MR. LARGE: Okay. Cap on noneconomic damages.

Now this is the issue we heard a lot of people talk about, and there was a lot of constitutional issues involved. There are three cases that are really the three cases that address this.

Page 256

The Kluger case, Smith versus Department of Insurance case, and the Escharte case, and there was two tests with three prongs that are important in that issue.

The first road or first test, is there a commensurate benefit provided to a claimant or plaintiff for a cap on noneconomic damages?

The second road with two prongs in it is, is there an overwhelming public necessity; and is there no alternative remedy?

So those are the constitutional issues that you are dealing with. At this point in

time you heard a lot of testimony on whether there should be a cap on noneconomic damages.

One of the issues also is perhaps what amount should there be if there is a cap on noneconomic damages?

MR. HITT: I think we need to look at the case. And the way I would phrase this, if I were just speaking on my own behalf, is I would like to see your best effort at justifying a cap on noneconomic damages under the constitutional test as you enumerated it, and I think that we almost have to do that.

MR. CRISER: Based on the record before this

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task force?

MR. HITT: Yes, including the data we got today, but certainly not limited to them. The issue for me would be whether it is feasible to look at caps of different sizes. Everyone cites the $250,000 cap that California put in effect, but that was done a long time ago.

MR. CRISER: 27 years ago.

MR. HITT: If you just put 2 or 3 percent on that, it would be a very different number today, annually. So --

MR. GAINOUS: Let me ask you, what are we voting on here?

MR. HITT: We would be voting on getting a report from William, a proposal, if you will, report to go in our reports as one of its legislative recommendation components.

MR. CRISER: That meets the constitutional test and is based on the record developed by this task force or other authority?

MR. HITT: I don't think I could make a judgment as to whether that would be done until I see William's report.

MR. GAINOUS: Whether there should be a cap on noneconomic damages until you see the report?

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MR. HITT: I am convinced by the actuaries, American Association of Actuaries' article that we

had for the last meeting that caps can, in conjunction with other reforms, can be effective in controlling costs, not in isolation.

I would like to see whether we can -- whether it's even feasible to propose it, because if they won't pass a constitutional test, there is no point in proposing it.

MR. GAINOUS: I struggle with the caps on noneconomic damages. On the one hand, I think perhaps we should, but then when I hear the preponderance of cases, I am thrown to believe that perhaps we should not. So I would like to see the information, and hopefully we'll decide at a later date if we would recommend a cap.

MR. HITT: Are you more comfortable if we treat it as sort of an expedited pass than a yes at this point? William has got to write the same report either way.

MR. LARGE: Mr. Chairman, my suggestion would be that his -- you vote yes on this, and ask me to write it up, and you have the opportunity to vote no in January when you review the report.

MR. HITT: All right.

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MS. SHALALA: I would reserve the right to vote no, depending on the information, constitutional information and -- which is what everybody else is going to do.

My linkage is also going to be whether we are offering an alternative system that's attractive, that's patient centered, as I indicated, as part of the package we are putting forward.

MR. HITT: We have gotten to the point where Mr. Beard and I have to leave pretty quickly.

MR. LARGE: Number 14 was yes?

MR. HITT: Yes. Task force members --

MR. LARGE: Five to zero, yes?

MR. HITT: 5-0, yes.

January 8th, 2003

A vote on caps did not take place on this date. However, during the course of discussing other items (primarily insurance reform issues), President Gainous asked for a clarification as to what was the reason and purpose for the December 20, 2002 vote on the cap on non-economic damages. As I did on December 20th, 2002, I re-explained the purpose of the December 20th, 2002 vote. More specifically, President Gainous remarked: **[Page 20, line 6]**, "I do not recall a vote in favor of non-economic damages, a cap on that…help me with that. As we discussed a cap on non-economic damages we voted to leave the matter on the table so that we could continue these discussions." From there, President Hitt assured President Gainous of his understanding, **[Page 20, line 16]** "Fred,…I thought the vote was in favor, but you had voiced some concern about it, and the reassurance was that no matter whether the vote was sort of neutral, keep it on the table or positive we would still look at it when it came back." From there, I further assured President Gainous that his understanding was, indeed, correct. **[Page 21 line 6]** "That subject [cap on non-economic damages] can be voted up or down once we review it. In other words, we've heard ideas, you will now see pen to paper on January 16th." President Hitt then agreed, **[Page 21 line 13]** "That was my understanding, Fred, that's what I was trying to convey."

January 8th, 2003

Page 3

You are going to have an opportunity to review that draft report and discuss it on January 16th. On January 16th upon reading the actual text of the draft recommendations you still have the opportunity to vote something up or down.

Page 4

So today, just like on December 20th, it is more of an opportunity to take things off of the table. So if you are not sure about an item perhaps you should ask me to continue to draft something for January 16th, but if you are opposed to an item you need to say so and take it off of the table.

Unlike our December 20th meeting where I could see everybody and I could see everyone raise their hand, it is very important that when we go through each issue that -- I am going to call roll this time and ask for a voice vote so that I know where we are on the issue.

And likewise there are three other

questions I would like to ask of the task force, procedural questions, at the end of our voting. But we want to make sure we go through the voting first

Let's go through our first four questions which we will judge each criteria by. Number one: Will the proposed change improve access to specialists or critical care providers or medical facilities for emergency care, obstetrical services,

Page 5

neurological services, or surgery?

Number 2: Will the proposed change facilitate the availability of malpractice insurance or other means for injured parties to recover reasonable compensation for injuries caused by the negligent acts of healthcare providers?

Number 3: Will the proposed change facilitate identifying and addressing healthcare provider problems as soon as possible to reduce or eliminate the risk to patients?

Number 4: Will the proposed change assist in reducing or holding down the cost of medical care to citizens and citizens health insurance providers to facilitate access to healthcare?

Those are the four questions that are going to sort of be a guide for us when we go through each proposal. We decided earlier on December 20th that a single proposal does not have to meet all four criteria, but the more criteria it meets the more likelihood that you will all probably vote in favor of it.

Page 19

But remember, you all have already voted in favor of at least having me write up the caps portion or write up a piece in

Page 20

favor of a cap on non-economic damages.

Voluntary binding arbitration --

MR. GAINOUS: Just a moment please.

MR. LARGE: Yes

MR. GAINOUS: I recall that discussion. I do not recall a vote in favor of non-economic damages, a cap on that

Mr. Chairman --

CHAIRMAN HITT: Yes.

MR. GAINOUS: -- help me with that. As we discussed a cap on non-economic damages we voted to leave the matter on the table so that we could continue those discussions.

CHAIRMAN HITT: I think the vote -- Fred, I don't have my notes from the meeting in front of me, I thought the vote was in favor, but you had voiced some concern about it, and the reassurance was that no matter whether the vote was sort of neutral, keep it on the table or positive we would still look at it when it came back.

MR. LARGE: The way this is working, President Gainous, is I recall that that was a vote in favor of me writing something up.

Page 21

MR. GAINOUS: Okay.

MR. LARGE: And I give you a written draft, which will be the subject of your discussion on the 16th.

MR. GAINOUS: Okay.

MR. LARGE: That subject and all subjects can be voted up or down once you review it. In other words, we've heard ideas, you will now see pen to paper on January 16th.

MR. GAINOUS: Okay. Thank you.

CHAIRMAN HITT: That was my understanding, Fred, that's what I was trying to convey

MR. GAINOUS: Okay. Thank you.

MR. LARGE: In fact, all of the

ideas we're going through right now today
you are just asking me to put pen to paper
on, all of the ideas that you vote in favor
of. The ideas you vote against I am not
going to write anything up on.

JANUARY 16th, 2003

January 16th, 2003 was meant to be the day that the task force actually reviewed written submissions that they had previously voted in favor of. The reason and purpose of each vote can be found in my initial instructions to the task force: **[Page 96 line 12]** "I have tried, to the best of my ability, to sort of capture the theme or the arguments that you all voted in favor of. But with each one of these products I can see you voting, you can vote yes, you can vote no. You won't hurt my feelings if you vote no. You can say something to the effect of, 'I still agree with the concept, I just don't like the way it is written.' You might say there is not enough information. You might say there is too much information. You might just get a red pen out and start crossing ~~things out and just start saying,~~ **[Page 97]** ~~'I don't agree with this.'~~"

During my questioning on July 15th, Senator Rod Smith seemed concerned that I had failed to bring up more flexible recommendations to the task force. Likewise, Senator King seems to have a similar concern as he mentioned my alleged failure to work on more flexible cap language in a press conference on July 16th, 2003. It appears that Senators King and Smith are both concerned that Donna Shalala's concerns about a more flexible cap were not addressed. Nothing could be further from the truth. In reviewing my testimony, I can see why Senator Smith was confused. He has failed to note that there was, indeed, an attempt to take a vote for a more flexible cap. Likewise, he failed to see that it was **my** recommendation! Finally, he failed to note that there was an attempt to draft up more flexible cap language. (However, these discussions took place on January 28th, and 29th). However, I don't blame Senator Smith for his confusion regarding the January 16th transcript: the court reporter apparently made an error on the top of page 125 of the January 16th, 2003 transcript.

Let me explain further. On page 98, President Shalala noted that she wanted a cap to be "more flexible." On page 98, line 23, President Shalala notes: "I for one, would like to see something a little fuller in that area." However, note where President Shalala wanted that "something" to be placed. On page 99, line 1, she stated, "as a possible recommendation, as opposed to an inflexible cap." It was apparently President Shalala's intention to bring up a flexible cap in the recommendation section of the report. You will soon see that no other participating member of the task force was interested in doing so. In sum, you will also see that the colloquy beginning on page 98 was not the substantive section on the discussion of caps; rather, it begins on page 120. On page 123, line 10 President Shalala again voiced her concern that she wanted a cap that was "more flexible and more predictable." However, as evidenced by the transcript **[Page 124 lines 11-25]** the other members of the task force voted 3-1 in favor of a cap on non-economic damages in the amount of $250,000.

Note how page 125 of the transcript begins: there is no identified speaker. One could assume that the speaker was President Shalala because she was the last speaker on page 124. However, the speaker then asks President Shalala a question: **[Page 125 line 4]** "Is that what you are asking me to do, President Shalala?" (It should be noted that I was the only one to call President Shalala "President Shalala" during the taskforce meetings. Everyone else usually called her "Donna".) In other words, page 125 should be properly read as my questioning the task force if they want to have another vote on a flexible cap! **[Page 125 line 1]** [**Mr. Large]** "Let's take a vote on another recommendation, simply that the task force recommends that there must be a cap of some sort that I can write that up. Is that what you are asking me to do, President Shalala?" I then ask the Task Force for a vote **[Page 125 line 9]** **"**What would be the vote on that?"

On Page 336 Line 12 of my July 15th, 2003 testimony, Senator Smith wrongly assumed that President Shalala asked for a recommendation. Senator Smith asked the following, "There was a request to take another vote, and the statement by Ms. Shalala, who apparently was one of the participants, Ms. Shalala said: 'Let's take a vote on another recommendation. Simply, that the Task Force recommends that there must be a catch [sic; cap] of some sort that I can write up. Is that what you're asking me to do?'" Senator Smith incorrectly assumed that President Shalala ~~had asked the question.~~ Once again, I don't blame Senator Smith, the transcript has been incorrectly transcribed.

In response to my request, Trustee Beard, notes: **[Page 125 line 11]** "The question would be it needs to be constitutionally-approved. I don't want to submit something that does not have a chance." It was quite apparent to me that Trustee Beard did not want to take a vote on language that was not actually in front of him. Since we didn't have any flexible cap language that satisfied President Shalala, I then made the suggestion that I would work with President Shalala to draft a more flexible approach. **[Page 125 line 15]** "Since we don't have something on that, perhaps we should not vote. I can work with President Shalala." President Shalala then promised: **[Page 127 line 7]** "I am happy to bring something forward." As you will soon see, President Shalala and myself did work to place language in front of the task force regarding a more flexible cap; however, it was voted down.

Although there is no evidence of the following in the record, at the conclusion of the January 16th, 2003 meeting, President Shalala asked me to work with her contacts from the Institute of Medicine and at Harvard University to see if we could possibly get language for a more flexible cap. She further informed me that she would also be contacting them to generate language for a more flexible cap. In fact, as I recall, she was quite confident that her contacts at the institute of medicine would be able to draft some type of flexible solution that would be amenable to the other members of the task force. As I recall, either on or shortly after January 16th, 2003, I contacted Dr. Michelle Mello at Harvard University regarding flexible cap language. It is my understanding that President Shalala also contacted Dr. Mello and/or several other prominent members of the Harvard faculty including: Troyen A. Brennen, M.D., J.D., M.P.H.; and David M. Studdert, LL.B., ScD., M.P.H.

On January 21, 2003, the following highly respected and distinguished academics responded to mine and President Shalala's request: Michelle M. Mello, J.D., Ph.D., M.Phil. (Assistant Professor of Health Policy and Law, Harvard School of Public Health); Troyen A. Brennan,

M.D., J.D., M.P.H. (Professor of Law and Public Health, Harvard School of Public Health; Professor of Medicine, Harvard Medical School); William M. Sage, M.D., J.D. (Professor, Columbia Law School); David M. Studdert, LL.B., Sc.D., M.P.H. (Assistant Professor of Law and Public Health, Harvard School of Public Health). These academics articulated that a $250,000 cap should be looked at in terms of Necessity; Fairness; and Feasibility. In sum, they recommended that a sliding scale approach be implemented, rather than a "procrustean" flat cap. This new approach was raised in front of the task force on January 28th, 2003. Moreover, a patina of these suggestions still remains in the actual task force report itself (See page 213). However, as the testimony of the January 28th, 2003 transcript reveals: these suggestions were voted down.

January 16th, 2003

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Here is how I envision this working.
What you have asked me to do is – we heard
verbal testimony on a lot of subjects.
Stakeholders at the same time presented

Page 96

written testimony. The quality of that
written testimony varied from power points
to actual legislative pieces, what have you.
That material, though, for the most part was
contained in your volumes.
What I have tried to do here is
extract those statements from the record,
the verbal statements, extract those
submissions that were presented, and put in
our binders for each topic, and write up a
piece for your review.
I have tried, to the best of my
ability, to sort of capture the theme or the
arguments that you all voted in favor of.
But with each one of these products I can
see you voting, you can vote yes, you can
vote no. You won't hurt my feelings if you
vote no.
You can say something to the effect
of, "I still agree with the concept, I just
don't like the way it is written." You
might say there is not enough information.
You might say there is too much information.
You might just get a red pen out and start
crossing things out and just start saying,

Page 97

"I don't' agree with this."

Page 98

MS. SHALALA: *In the discussion of*
the cap on economic damages, I think that
while many of us think that it may be
critical to malpractice, some of us may
believe that the cap has to be more flexible
within certain financial parameters, as
opposed to an overall cap, because part of
the concern is about the catastrophic
situation and also about the
constitutionality.
As you know, I have expressed some
interest in the State Workers' Compensation
system and in the possibility of combining
flexible caps with predictable payouts and
safety regulations. So I think, at least I
for one, would like to see something a
little fuller in that area.
MR. LARGE: *Okay.*

Page 99

MS. SHALALA: *As a possible*
recommendation, as opposed to an inflexible
overall cap.
MR. LARGE: *Okay.*
MS. SHALALA: *Along with the quality*
stuff, as well as the discipline material.
And the other piece in the
discipline area is whether to provide
immunity to organizations, to hospitals and
other kinds of healthcare organization when
they discipline physicians who consistently
perform in a substandard manner, because
that's the other part of this. It is not
simply beefing up the state's own mechanism.
It is when the healthcare institution wants
to do the discipline on whether they're
going to have some immunity as part of that

process.
It is just a different layer of sophistication in both of those cases. So those are the areas where I would like to see a little bit more writing.
MR. LARGE: Okay.
MR. BEARD: William, my sense is that I don't have a big problem with the

Page 100

amount of the caps. But I want to make sure that we're able to prove that caps will work. And I am not sure what legally that needs to be.
An undefined cap is going to be difficult for us to deal with, I think, without some kind of proof that it works.
MR. LARGE: Okay. This here is my suggestion is that we go through it topic by topic, like everything that I have written up. For example, President Shalala, what you mentioned about caps, that we could go through that and say, right over here, William, you need to strengthen this piece up, and you need to add that.

Page 120

MR. LARGE: Okay. Next is the cap on non-economic damages. This is an issue that we heard a lot about from a lot of different stakeholders.
CHAIRMAN HITT: Well, it is probably the one that will attract the most attention yea and nay right across the board.
I have kind of come around in a

Page 121

circle on this one. I was one who spoke in terms of -- or in favor of considering a different amount than the $250,000. I guess I have come back to the viewpoint that we're going to be challenged on this inevitably

we'll be challenged. And we want to have the best case we can make for an efficacious measure.
And the data we have, it seems to me, all deal with the $250,000 cap. So I have been persuaded to move back from my earlier position of saying that the cap ought to be reconsidered and perhaps adjusted for inflation or be made flexible in some way. And my own feeling now is that we would be better advised to recommend the $250,000 cap as William's write-up does. And if that amount is to be tinkered with, let the Leglislature do that.
I am sure there will be a lot of discussion about it. The very concept is highly controversial. And the amount of it certainly will be discussed. But from our standpoint having to produce a report that makes a convincing case that a cap will have

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some effect, it does seem the evidence is all based on a $250,000 cap.
MR. LARGE: Okay.
MR. BEARD: It's the only issue we're dealing with that evidence is out there with long periods of time. So I am with you, President Hitt.
MR. CRISER: I concur in the two previous statements.
CHAIRMAN HITT: Donna, I know you voiced this morning a somewhat different view.
MS. SHALALA: I do have a different view. It is not that I am opposed to the cap. I want to make that very clear. It is just that I just think that the cap has to flexible within certain financial parameters.
I mean, I just think an inflexible cap does not answer the question on where you have a catastrophic situation, and that we would be better off with something like the Workers' Compensation system with a

flexible cap with predictable payouts and with safety regulations combined with them.

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I would like something a little bit more robust. We have been down the road of the caps. How rigorously we can defend this constitutionally, I just think that we're beyond that now in this business, and that we ought to at least see a write-up on something a little bit more substantial before we take a final vote on a simple cap. I am not objecting to a cap. But I would like to see a system that is more flexible and more predictable
CHAIRMAN HITT: How would we get to that proposal?
MS. SHALALA: I think that part of the Institute of Medicine recommendations -- that there really are recommendations out there that we could incorporate as part of the quality movement.
And I think we've talked about some of the other pieces. Part of the quality piece, the discipline piece, and then a cap, all of those pieces together.
CHAIRMAN HITT: I think we want the package, but it will have to have a cap component.

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MS. SHALALA: I am not disagreeing with a cap component. I'm simply saying I would like an alternative to simply a simple -- an alternative to a simple overall cap, and that would be a more flexible system modeled on the Workers' Compensation system, which is flexible depending on the severity.
But I agree with the predictability, with all of the elements you get with a cap.
MR. LARGE: Let's do this. This recommendation here, let's make sure we're clear on the record. The task force

recommends that medical malpractice cases non-economic damages be capped at $250,000 per incident. Let's take a vote on that.
Chairman Hitt.
CHAIRMAN HITT: Yes.
MR. LARGE: President Criser?
MR. CRISER: Yes.
MR. LARGE: Mr. Beard?
MR. BEARD: Yes.
MR. LARGE: President Shalala?
MS. SHALALA: That is a 3-1 on the 250 number.

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[MR. LARGE]:
Let's take a vote on another recommendation, simply that the task force recommends that there must be a cap of some sort that I can write that up. Is that what you are asking me to do, President Shalala?
MS. SHALALA: Yes. And I'll help write up that section, so everybody can look at it.
MR. LARGE: What would be the vote on that?
MR. BEARD: The question would be it needs to be constitutionally-approved. I don't' want to submit something that does not have a chance.
MR. LARGE: Since we don't have something up on that, perhaps we should not vote. I can work with President Shalala.
CHAIRMAN HITT: I would like to see an attempt made. If there is something that we can propose that has a chance of being held constitutional, I had earlier expressed the need for some flexibility. And my only reason for backing off on that is a concern that, absent a database upon which we -- or to which we can refer that shows it will be

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effective, it will not be sustained in the courts.

So if we can answer that concern with an alternative that is more flexible, then I would be happy to vote for it.

MR. BEARD: *Maybe we deal with it on -- with some kind of footnote that says that there is nothing. The special piece of the 250 is the constitutional and the provability of it. But if something else is accepted, there is nothing magic about 250 that has been in place for 27 years in California, other that it is the data.*

I would have a hard time changing, going away from the 250, unless there is some sort of provability that we can get, that it will work. I mean, that we can get it through, and it becomes law, instead of getting it through, and it becomes thrown in the trash by the Supreme Court.

CHAIRMAN HITT: *Exactly.*

MR. LARGE: *All right. So we have a 3 to 1 vote that the task force recommends that medical malpractices non-economic damages be capped at 250,000 per incident,*

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correct?

CHAIRMAN HITT: *Correct.*

MR. BEARD: *Right.*

MR. CRISER: *We're willing to look at something else if somebody wants to in the next week develop something*

MS. SHALALA: *I am happy to bring something forward.*

January 28th, 2003

A fair reading of the January 28th, 2003 transcript reveals that President Shalala tried to convince the other members of the task force to adopt a flexible cap. She referred to the language that the academics from Harvard and Columbia had raised. However, the task force did not embrace the flexible cap concept. Although an actual vote did not occur on January 28th, 2003, a fair reading of this transcript reveals that the task force members were not inclined to vote for any flexible cap solutions. At each of President Shalala's suggestions, the other members voiced their objections as to why they were opposed to a cap.

For example, on page 63 of the January 28th, 2003, transcript, President Shalala advocated that any cap that was voted on should have a sun set provision. On page 64 of the transcript, President Hitt rejected this idea. **[Page 64 line 22]** "[T]he only problem I see with the sunset is you have got such a long tail on these complaints that six years, you might not -- you wouldn't have a whole lot of experience. A lot of the problem that you try to address with a cap is uncertainty. So I'm not sure that the cap could work the way we believe it will if it had a sunset even as far out as six years." Trustee Beard offered similar comments: **[Page 66 line 12]** "I don't think it helps." President Criser agreed with Chairman Hitt's comments: **[Page 67 line 12]** "Number 1, we're told that the problem in setting malpractice insurance premiums is the lack of certainty. If you have a six-year period and then a sunset, or that we ask the Legislature to revisit it, it seems to me you are taking out the certainty, because we have a four-year statue of repose, and then you have this tail that goes on, but the uncertainty is still going to be there." Based on the comments of the other task force members, President Shalala did not ask for an official vote on the sunset of the cap; however, this concept was implicitly rejected by the task force.

During the course of the January 28th, 2003 meeting, President Shalala also attempted to raise the subject of a flexible sliding scale cap on non-economic damages. **[Page 69 line 18]** "What we do is describe a more flexible sliding scale. There is language for this. In fact, there was a New York Times editorial a couple of weeks ago on exactly this subject." Trustee Beard immediately rejected this concept: **[Page 69 line 23]** "Donna, this is something we really have not studied in this committee." President Criser echoed similar comments: **[Page 71 line 20]** "I think under the case law in order for this court to be held openly constitutional, we have got to base it on a record that we've assembled here with a $250,000 cap. Anything that we do, go beyond that may be a good idea, may be conjecture, may be visionary, but we have not got a report to substantiate it." Thus, a fair reading of the transcript reveals that a sliding scale flexible cap was also implicitly rejected by the task force.

From there, President Shalala again raised the issue of whether $250,000 was the appropriate number. **[Page 72 line 3]** "Could I also raise the issue of whether $250,000 is the appropriate number?" Trustee Beard responded, **[Page 72 line 6]** "It is the only one that we know works." Chairman Hitt voiced the same concern: **[Pages 72-3, lines 24-8]** "Donna, you know I'm sympathetic to a more flexible cap, and have talked in the open public meetings about wanting to look at other numbers. But I just became convinced that it is going to be hard enough to have this sustained on constitutional grounds with the best evidence we've got. And I am afraid that liberal minds are going to say, 'The only evidence you have got is for a 250,000 cap.'" As such, a fair reading of this transcript reveals that the task force rejected any number other than $250,000.

January 28, 2003

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MR. LARGE: *Okay. Alright. We have a quorum. Mr. Chairman, this is I think the best way to go through the agenda.*

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Excuse me, not the agenda, the report.

I have sent you all a report that consists of 336 pages. You have seen pages 141 through 336 in another form. Those were the substantive pieces that you all reviewed on January 16th.

At the time you reviewed them on January 16th, they were separate documents. I have now made them into one master document, and I have given them chapters. For example, Chapter 6 is now quality health care. Chapter 7 is physician discipline. Chapter 8 is tort reform. Chapter 9 is alternative dispute resolution. And Chapter 10 is insurance reform.

But you all have seen that in another form. I have edited some errors and mistakes that were in the original documents, but you have seen pages 140 through 336 in another form.

What you haven't seen before this meeting is Chapters 1 through 4. Let me explain to you what I have done on Chapters 1 through 4.

Chapter 1 is essentially just a

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Mr. Chairman, that is what everybody should have in front of them. And I think perhaps one of the best ways to go through this is perhaps chapter-by-chapter and explain to you any differences in this document that may be present from the January 16th vote.

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MS. SHALALA: *Yes. Do we have time to go back to the non-economic damages discussion?*

CHAIRMAN HITT: *Yes. We have plenty of time on our schedule. I don't know what other pressing things you have got, but we are scheduled for another couple of hours.*

MR. LARGE: *Okay. That is -- Chapter 8 begins tort reform. And from there, the first topic under Chapter 8 is the cap on non-economic damages.*

MS. SHALALA: *First, we don't have any indexes.*

MR. BEARD: *You have to give us the page number.*

MR. LARGE: *Okay. It is page 179. It is page 179.*

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MS. SHALALA: *The recommendations are not on page 179.*

MR. LARGE: *No. That begins the discussion.*

MS. SHALALA: *Where are the recommendations?*

MR. LARGE: *The recommendations are on page 211.*

CHAIRMAN HITT: *One paragraph under recommendations.*

MS. SHALALA: *The first question is whether anyone is interested in the possibility of sunsetting the cap, asking the Legislature to establish a cap, and then sunsetting it six years from then with a study that accompanies it which would at least answer the question of whether the cap actually works.*

The cap would be on only cases arising out of injuries occurring over the next five or six years, for example. That would solve the problem of whether we're dealing with an immediate insurance crisis. It also allows us to study it during a period of time, and it gives the Legislature

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time to look at more radical reform.

You know, I have always been interested in the Workers' Compensation scheme of defined benefits which actually denied -- might entirely deny litigation

remedies.

But the advantage here is that we go to a path, put a sunset in it, study it during that period, but at the same time have the Legislature appoint a body to look at something more radical to get us out of litigation completely.

I just think that that kind of approach, no matter how complex it is, might be less controversial from a constitutional point of view. But it takes some time to put in place that kind of an approach.

It also gives us a good hard look of whether a cap actually works to drive down costs. Putting it in place during a crisis is exactly the right thing to do, I think.

CHAIRMAN HITT: Well, Donna, the only problem I see with the sunset is you have got such a long tail on these complaints that six years, you might not --

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you wouldn't have a whole lot of experience. A lot of the problem that you try to address with a cap is uncertainty. So I'm not sure that the cap could work the way we believe it will if it had a sunset even as far out as six years.

Do others have reactions to that?

MS. SHALALA: What's the average time on these cases?

CHAIRMAN HITT: Well, you've got up to a four-year period for discovery, in effect, don't you?

MS. SHALALA: What is the actual experience?

MR. LARGE: Well, that's discussed is Chapter 3. There is a section on -- I call it lag time. And talk about -- we have a citation to Dr. Sloan indicating the average life span of a medical malpractice case is between about two and five years.

From there, we have a citation to Chapter 95, Florida Statutes, regarding the statute of limitations and the statute of

repose, and a discussion about this lag time that in medical malpractice insurers face,

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that insurers in other lines, such as auto insurance, don't necessarily face.

MS. SHALALA: What if we didn't put a legal sunset on it, what if we just said that the Legislature ought to review it in six years?

MR. BEARD: I don't know. What that does -- it is kind of like inheritance taxes, which go away for 11 years and then come back. I mean, all of the structure continues to stay in place for everything. I don't think it helps.

MS. SHALALA: My concern is that a cap alone from my point of view doesn't necessarily change the culture. To put all of our money on the cap, even while we're doing some of the things to strengthen discipline -- I just would like to see the State explore something more expansive that would actually eliminate litigation.

CHAIRMAN HITT: Donna, I like the cap, but I don't think a cap alone will do the job. I think you need cap and. But the other stuff without the cap, at least as far as I have seen in the literature, is not

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going to be effective. So --

MS. SHALALA: I'm perfectly willing to vote for a cap. I just want to make sure that we put some other language on this that makes it very clear that the Legislature have to do all of the other things we're recommending in terms of discipline. And that gets them to start exploring, actually putting a system in place modeled on Workers' Compensation that actually eliminates litigation

MR. CRISER: Let me respond to two points.

Number 1, we're told that the problem in setting malpractice insurance premiums is the lack of certainty. If you have a six-year period and then a sunset, or that we ask the Legislature to revisit it, it seems to me you are taking out the certainty, because we have a four-year statute of repose, and then you have this tail that goes on, but the uncertainty is still going to be there.

MS. SHALALA: What about asking the Legislature to look at a system that

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basically puts in place something that eliminates litigation?

MR. CRISER: No state has gone to a no-fault as they have with automobile insurance, have they, William?

MR. LARGE: The two no-fault models that are out there are in Virginia and Florida for the Neurological Injury Compensation Act. The best examples of no-fault other than that would be Sweden and New Zealand, not in another state.

MS. SHALALA: The thing is that -- the reports that Don Berwick and others gave us is that they're really recommending that we find a substitute for the current system. While I believe the cap will help, I do think that we ought not to lose the opportunity to urge the Legislature to put a more fundamental system in place that provides for the certainty and the timeliness that has a more flexible cap, which a Workers' Compensation type system would have. It would have all of the elements, but it would get you completely out of the court.

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CHAIRMAN HITT: If I may -- and this is really subjective --

MS. SHALALA: I'm not asking for a substitution. I am simply asking that at the same time that we recommend a cap, that we also say that the State ought to explore a more fundamental change.

CHAIRMAN HITT: I've got no problem with that, Donna. The thing that I was going comment on is, if we make reference to Workers' Comp as a model, I don't know that we're going to be helping our case with the Legislature, because I think-- and correct me if I am wrong here, folks -- I think there is a perception that there are still a lot of problems with Workers' Comp out there.

MS. SHALALA: What we do is describe it as a more flexible sliding scale. There is language for this. In fact, there was a New York Times editorial a couple of weeks ago on exactly this subject.

MR. BEARD: Donna, this is something we really have not studied in this committee.

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MS. SHALALA: That's why I think that our recommendation ought to be that the Legislature or the Governor appoint a group to take a look at a different system that would totally get us out of the court system.

MR. BEARD: Isn't that something that would normally happen if the things that we do in this committee and recommend and if they get instituted by the Legislature, if they go in place and we still have the same issues and the same problems, my guess is that they would be studying it again.

MR. CRISER: That's why we're the fourth group that has studied this.

MR. BEARD: That's right. It will just naturally happen. If what we have done works, then they may not study it again, and maybe we've done our job. I just don't see a need to say, "Why don't you guys study it

again later and find a better system."
MS. SHALALA: Well, we're only offering a partial solution that doesn't solve the issue of going to court. And my

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argument is that even while offering that, that there are lots of ideas out there, including something for a much more flexible system that would end litigation in this area.
MR. BEARD: That would be the best of all worlds, but --
MR. LARGE: Perhaps we can put that in a conclusion section for the entire document, rather than in the caps section, that there are ways to improve our system; something to that effect.
And, President Shalala, when I speak to you on the phone, perhaps I could get your thoughts on that as well.
MR. BEARD: Maybe what you do is you say that we know that there are other things that haven't been tried before that might be better, but this is what we're recommending.
MR. CRISER: I think under the case law in order for this court to be held openly constitutional, we have got to base it on the record that we've assembled here with a $250,000 cap. Anything that we do, go beyond that may be a good idea, may be

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conjecture, may be visionary, but we have not got a report to substantiate it.
MS. SHALALA: Could I also raise the issue of whether $250,000 is the appropriate number?
MR. BEARD: It is the only one that we know works.
MR. LARGE: This was my concern in writing this report, is right now the only facts that we have out there to support a number is the $250,000 number. If another

number would work, it is conjecture right now. We don't have any basis to support it or any studies to support some other number. It would just be hypothetical. Two fifty is the only number that has been proven to work, so that --
MS. SHALALA: Is the data that the cap works or the 250 works?
MR. LARGE: The data is the cap works at 250.
MS. SHALALA: I will look at the language when we write this up.
CHAIRMAN HITT: Donna, you know I'm sympathetic to a more flexible cap, and have

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talked in the open public meetings about wanting to look at other numbers. But I just became convinced that it is going to be hard enough to have this sustained on constitutional grounds with the best evidence we've got. And I'm afraid that liberal minds are going to say, "The only evidence you have got is for a 250,000 cap."
MS. SHALALA: Well, let me see what we could do in terms of writing up future things to be explored by the Legislature and by the Governor.
CHAIRMAN HITT: Okay.

January 29th, 2003

As with the January 28th, 2003 meeting, this meeting specifically focused on redrafting and editing the final document. Moreover, an emphasis was placed on editing the actual recommendations that appeared at the end of each chapter, in the executive summary, and in the conclusion. When it came to the recommendation regarding a cap on non-economic damages, President Shalala wanted new language to be added. President Shalala noted that she would vote for the recommendation regarding a cap on non-economic damages if language was inserted that the efficacy of the cap would be studied sometime in the future. **[Page 61 line 23]** "I would like to vote for this, if you will add a study on its impact." President Criser agreed with this suggestion. **[Page 61 line 23]** "I'll go for a study, but I don't think I will go for a sunset." President Hitt also agreed, **[Page 62 line 20]** "I think that's a good idea. And I think it would in some ways reflect some of the criticism we're likely to get. It is pragmatic to make sure we know

what we've done." The Task Force the re-voted on the cap on non-economic damages recommendation with President Shalala's new study language included.

January 29, 2003

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MR. LARGE: I will add that.
That brings us to recommendations. Once again, the recommendation section, when I pulled them from all of the chapters, they were written in a different style in the sense that some recommendations were in a bullet point format, like I have them now, others were a lot more lengthier. And I felt that in an executive summary format, we should get right to the point in terms of our recommendation.
If there was a reader that wants to go back to the substantive chapter and the

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substantive chapter's conclusion with the recommendations, they can do so. So a lot of these recommendations, if you were to turn back to the chapter, what you will find is maybe more text.
MS. SHALALA: Let's talk about this a little bit.
MR. LARGE: Okay.
MS. SHALALA: I think the text is so dense. William, if you had another month, you could really cut it down. I am very concerned that maybe even if we had to add two more pages to the executive summary, it it would be worth it, so that it was freestanding, so it was actually more understandable.
So I think the idea of adding three or more sentences to each of the recommendations we should not avoid, because I do think that large numbers of people are actually going to read the recommendations. They ought to be able to read them without

referring back to the text.

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MR. LARGE: I am dropping all of the recommendations now from the chapters to the executive summary.
MR. BEARD: Right.
MR. LARGE: This is the one for caps on page 211 of Chapter 8.
MR. BEARD: It is one recommendation, right?
MR. LARGE: That's right.
MR. CRISER: You will show that in toto subject to whatever comment we will

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hear about the caps at this point.
MR. LARGE: Right.
What are your thoughts on this recommendation on page 211?
MS. SHALALA: Well, let me do editing things first. Although the task force was offered other solutions or reviewed other solutions, there is no other alternative remedy that will immediately help.
CHAIRMAN HITT: We've heard some argument that even with caps, this might take more than a year.
MS. SHALALA: But that's immediate, compared to designing a new system I think.
MR. LARGE: Okay.
MS. SHALALA: I would like to vote for this, if you will add a study on its impact.
MR. CRISER: I'll go for a study, but I don't think I will go for a sunset.
MS. SHALALA: Pardon?
MR. CRISER: I'll go for a study, but I don't think I will go for a sunset.
MS. SHALALA: I'm asking for a

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study. I have not raised the other issue. And I would like to send you language on a study.

The important thing is to study its impact. So the Legislature can review it without using the word sunset.

CHAIRMAN HITT: For what period of time, Donna?

MS. SHALALA: I think most people think you have to look at it for five years to actually see its impact. Report to the Legislature in five years, or an interim report to the Legislature in five years. How is that?

CHAIRMAN HITT: All right

MS. SHALALA: The Legislature ought to fund it.

MR. LARGE: Okay.

CHAIRMAN HITT: I think that's a good idea. And I think it would in some ways reflect some of the criticism we're likely to get. It is pragmatic to make sure we know what we've done.

MR. LARGE: Okay. So, everyone,

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we'll have a vote on recommendation on the cap on non-economic damages on page 211.

CHAIRMAN HITT: Modified with the addition of the study.

MR. BEARD: In five years.

MS. SHALALA: And I would use the word interim report to the Legislature in five years.

CHAIRMAN HITT: All right.

MR. LARGE: I want to get a voice vote on that.

President Hitt?

CHAIRMAN HITT: Yes.

MR. LARGE: President Criser?

MR. CRISER: Yes.

MR. LARGE: Mr. Beard?

MR. BEARD: Yes.

MR. LARGE: President Shalala?

MS. SHALALA: Yes.

MR. LARGE: And has President Gainous called in?

MS. SHALALA: I'm sorry, I have to go.

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MR. LARGE: Let's do this. Let's go back to the executive summary. We sort of turned off -- went off the executive summary page for -- each recommendation then starts to look at the actual substance of the -- is everyone okay with what I wrote in the end of the executive summary?

MR. BEARD: I think you should

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say -- well, you do, reforms are important.

CHAIRMAN HITT: What are you referring to, William?

MR. BEARD: The last paragraph on the last page of the executive summary: "The task force respectfully finds"...

CHAIRMAN HITT: Okay. The thought that I had -- my summary thought on the caps in their centrality was that study that -- I can't remember the authors, but they were actuaries, and they had compared results in states, from state-to-state.

And without a cap, the other stuff didn't work.

MR. LARGE: We heard a lot of people -- Milliman talked about that, that was Richard Beoni, Jim Hurley talked about that, Dr. Richard Anderson talked about that.

CHAIRMAN HITT: You gave us that one reprint of the study from the actuary journal, as I recall. And they even showed states like -- I believe it was Ohio there was originally a cap, and the expenses were falling in line. As soon as the cap was

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stricken by the court, you saw the costs go way back up.

MR. LARGE: Right. So is everybody okay with the statement under insurance company regulations, and it sort of kind of ends the document? When it starts with: "The task force respectfully finds and concludes?"

MR. BEARD: You know, I guess all of the other recommendations are as important. It says they're important.

We want them to deal with all of these issues if we can, because what if the Supreme Court throws this thing out again?

MR. CRISER: We don't want this to be the sole issue. But we believe it is the rock, the foundation of a reformation of the existing crisis.

MR. BEARD: Right.

MR. CRISER: I think we have to say it as many times as we can, because as I understand it, when the senate had their briefing here a couple of weeks ago, the only two witnesses they had on the subject of capping non-economic damages were two

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people who opposed them; a professor from Delaware and a professor from Colorado or something.

So, you know, our position is that for this to work, the only verifiable data is that this number and in this form. They will do as they decide they want to do.

MR. LARGE: That's what this paragraph is meant to say.

CHAIRMAN HITT: Right.

MR. BEARD: Right.

MR. CRISER: I think it has to be said. But we don't want to say that it is not a comprehensive set of recommendations, but the bedrock is the cap.

CHAIRMAN HITT: I'm wondering, really, William, if this goes as far as I would based on that article. It says that

it will have the greatest long-term impact. What I recall is that you are really not going to get the results you want without a cap.

MR. LARGE: That's true.

MR. BEARD: All of the other things are tinkering with the system a little bit,

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but the cap is almost mandatory.

MR. LARGE: Yes. So do you want me to start with that?

CHAIRMAN HITT: That goes a little further than what your paragraph now says.

MR. CRISER: I think you ought to strengthen that, William.

MR. LARGE: Okay. Strengthen this paragraph.

CHAIRMAN HITT: As they attack in the court, they're going to say that the cap is not really necessary. And what has brought me to be willing to vote for it is that I think it is necessary, because I think some of the critiques of caps are on target, that they really do penalize most of the people who are injured the most severely, but I think they get a commensurate benefit because this is the only way to cure the faults in the system.

MR. CRISER: I think those conclusions are necessary under the Kluger case and under the Smith cited case.

CHAIRMAN HITT: Yes.

MR. LARGE: All of those statements

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are in there in the substantive section.

CHAIRMAN HITT: The first thing you read and the last thing you read is what you remember. I would hit it hard right here at the end. You've got a good summary statement, but I think it is strengthened if we, in effect, say none of the rest will -- all of these other things are important, but

even combined, they wont' get the job done without a cap.

MR. LARGE: *Okay. Will do. So we're going to meet tomorrow at 4:00.*

MR. BEARD: *That's the plan.*

CHAIRMAN HITT: *Yes.*

MR. CRISER: *Yes.*

CHAIRMAN HITT: *We don't' have Fred and haven't, and I don't know whether that's coincidence or whether Fred just didn't want to vote for a cap or what. We don't' have any idea really why Fred has not been here. We do have a 4-0 vote on the cap. Everyone who was present and voted voted in favor.*

MR. LARGE: *That's correct.*

CHAIRMAN HITT: *I think we've had either unanimous or very close to it votes*

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on all of the other issues.

MR. LARGE: *That's correct.*

CHAIRMAN HITT: *So that ought to be stated if we can.*

MR. LARGE: *Yes.*

MR. CRISER: *I think it needs to be stated. I think what we have or will have by tomorrow afternoon is a 4-0 vote for this report with President Gainous not participating.*

January 30th, 2003

On this date, a final draft of the task force report was presented to the task force. A voice vote was taken approving the entire text of the report, including the recommendation regarding a $250,000 cap on non-economic damages.

JANUARY 30, 2003

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the words recommendation 2 and just integrate it into the recommendation. Make it a separate paragraph, a separate

recommendation.

MR. CRISER: *We want to be firm on our recommendation on the cap.*

MS. SHALALA: *Yes, I understand that. What I would do, though, is just take out the word recommendation 2, just make it the second paragraph under the recommendation, as opposed to making it a separate recommendation.*

MR. CRISER: *You are saying: "In addition, the Legislature should commission and fund a study?"*

MS. SHALALA: *Sure. I just would not elevate it to a separate recommendation, but rather integrate it. In addition is fine. But I would make it a separate paragraph there, and just start it with in addition.*

CHAIRMAN HITT: *Okay.*

MR. LARGE: *Okay. The other big issue you asked for is, if you can turn to Roman numeral XV, you asked me to beef up*

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the findings on the cap issue. And so beginning on Roman numeral XV I have an issue brief all the way through lower case Roman numeral xvi. Previously, the only paragraph was the last one found on page 16. So this is -- there is now --

MR. BEARD: *I like talking about California.*

CHAIRMAN HITT: *Yes.*

MR. LARGE: President Hitt, you asked about the Academy of Actuaries' study, so that's in there.

CHAIRMAN HITT: *Good.*

MS. SHALALA: *On 15, I mean XV, is there a transition problem there?*

MR. LARGE: *On what page?*

CHAIRMAN HITT: *Should we put something like conclusion?*

MS. SHALALA: *You have to either put 3 after it or something, so that there is a break there.*

CHAIRMAN HITT: *We go from insurance company regulation to our conclusory statement of the caps.*

MR. LARGE: *Okay. I will put maybe*

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the word conclusion there or something like that.

CHAIRMAN HITT: *It really does not tie to the previous recommendations, which are the insurance --*

MR. LARGE: *Right.*

CHAIRMAN HITT: *-- so we need to separate it. Donna is right. I think you could just put a string of asterisks there, but --*

MR. BEARD: *Call it a conclusion.*

CHAIRMAN HITT: *Conclusion.*

MR. LARGE: *And I might have an introductory clause, although all of the above issues are important, and then bring ourselves into what is on pages 15 and 16.*

The other major change was on page -- Roman numeral III, we went by that. This was President Criser's suggestion. "It must be emphasized that in order to properly understand the context of these findings and recommendations, it is incumbent" --

MR. BEARD: *Tell me what page you are on again.*

MR. LARGE: *Roman numeral III.*

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MR. CRISER: *Roman numeral III?*

CHAIRMAN HITT: *The very beginning. The second page of the executive summary, but it's Roman numeral III.*

MR. BEARD: *I got you.*

MR. LARGE: *The last sentence there. "Thus, it must be emphasized that in order to properly understand the context of these findings and recommendations it is incumbent*

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CHAIRMAN HITT: *Absolutely.*

MR. LARGE: *From there, I just want to make sure the record is clear, everyone is in agreement of the text and content of the entire report. I know there are some wordsmithing that still needs to be done as indicated by President Shalala's edits that she's going to send in.*

I just want to make sure the record is clear that there is a vote in favor of this entire report as it exists.

CHAIRMAN HITT: *Yes. Let's do a voice vote on the entire report in its final substance, understanding that there will be a little wordsmithing and editorial work done yet.*

MR. LARGE: *President Hitt?*

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CHAIRMAN HITT: *Yes.*

MR. LARGE: *President Shalala?*

MS. SHALALA: *Yes*

MR. LARGE: *Mr. Beard?*

MR. BEARD: *Yes.*

MR. LARGE: *President Criser?*

MR. CRISER: *Yes. And in the report make it clear that it was a four -- four votes in support of it.*

MR. LARGE: *Okay.*

CHAIRMAN HITT: *Yes, unanimous of those present and voting.*

MR. LARGE: *All right.*

d) Please provide the vote count of each vote, and indicate who voted in the affirmative and the negative on each vote.

ANSWER:

December 20th, 2002.

This was a vote to put pen to paper and write up a section regarding a cap on non-economic damages.

Hitt Yes

Criser Yes
Gainous Yes
Shalala Yes
Beard Yes

January 16th, 2003

This was a vote to adopt language that supported a $250,000 cap on non-economic damages.

Hitt Yes
Criser Yes
Gainous Absent
Shalala No
Beard Yes

January 28th, 2003

This was primarily a discussion of the edits and redrafts of the January 16th, 2003 document. As far as the cap on non-economic damages was concerned, there was an implicit rejection of a sunset of the cap sometime in the future. Although there was no official vote, Chairman Hitt, Trustee Beard, and President Criser rejected the idea of a sunset for the cap. Likewise, there was an implicit rejection of a more flexible sliding scale cap. Finally, there was an implicit rejection of using any number other than $250,000 dollars as a cap on non-economic damages. (It should also be noted that President Gainous was not present for these discussions.)

January 29th, 2003

As with January 28th, 2003, this was primarily a discussion of the edits and redrafts of the previous meeting. The task force also wanted to focus on the executive summary and the recommendations found in the executive summary. President Shalala specifically asked that the following language be placed in the executive summary regarding the cap on non-economic damages: "The Legislature should commission and fund a study of the impact of the $250,000 cap on non-economic damages. An interim report should be submitted to the legislature five years after date of enactment." Due to the result that the recommendation on the cap on non-economic damages had been changed, I asked for a voice vote regarding the approval of the new recommendation. This vote was with respect to a $250,000 cap on non-economic damages as well as a corresponding study to determine its efficacy.

Hitt Yes
Criser Yes
Gainous Absent
Shalala Yes
Beard Yes

January 30th, 2003

The purpose of this vote was to approve the entire text of the task force report, including, the recommendation regarding the $250,000 cap on non-economic damages. The cap recommendation regarding the cap had been changed the day before as a result of a suggestion by President Shalala. This was the first opportunity for the Task Force to actually see the typed up recommendation, which is Recommendation number 27 in the final task force report.

Hitt Yes
Criser Yes
Gainous Absent
Shalala Yes
Beard Yes

In conclusion, I trust that this explanation answers your concerns. However, I feel compelled to point out two additional matters. In the July 15, 2003 transcript, I am quoted as saying **[Page 327 line 13]**, "This section [(cap on non-economic damages)] was perhaps the '**easiest**' issue of the Task Force." The court reporter has erroneously transcribed this word. It should read, "This section was perhaps the '**sexiest**' issue of the Task Force." (By no means was anything about this issue "easy").

Finally, on pages 341-343 of my July 15, 2003 transcript, I think I left you confused about the data from the National Practitioners' data bank. The Milliman report extracted **Florida** data from the National Practitioner data bank. I apparently wrongly left you with the impression that the National Practitioner data was from the rest of the states. I apologize. Once again, thank you for inviting me to the committee to discuss this matter. I wish to commend both the Senate and yourself for your sincere commitment to crafting a resolution to this problem.

Respectfully,

William W. Large
Executive Director
Governor's Select Task Force on Healthcare Professional Liability Insurance

cc: The Honorable J. Dudley Goodlette,
Chairman of the House Select Committee on Medical Malpractice Reform

Mortham

THE FLORIDA SENATE

COMMITTEE ON JUDICIARY

Location
515 Knott Building

Mailing Address
404 South Monroe Street
Tallahassee, Florida 32399-1100
(850) 487-5198

J. Alex Villalobos, *Chair*
Dave Aronberg, *Vice Chair*
Dawn Roberts, *Staff Director*
Senate's Website: *www.flsenate.gov*

July 29, 2003

Sandra Mortham
Executive Vice President
Florida Medical Association
113 East College Ave.
Tallahassee, FL 32301

Dear Ms. Mortham and Mr. Scott:

In reviewing the transcript of the Senate Committee on Judiciary meeting on July 14-15, 2003, we have identified several occurrences where you were asked to provide information subsequent to your testimony. Additionally, the committee has identified certain issues for which it requests additional information. Specifically, we request a response in the following instances:

1. How many Florida licensed physicians are members of the Florida Medical Association (FMA)?
2. How many physicians ceased the practice of medicine in Florida last year? During the last 5 years? Please produce any records in support of the figures you provide in your answer.
3. What are the insurance premiums available to specialists in Miami-Dade for $250,000 policies? What about for $500,000 policies? Please include obstetricians, radiologists, neurologists, orthopedic surgeons, and emergency room physicians.
4. Please provide an exact incident(s) of a particular patient that has been denied access to care. Please provide any documentation in support of this allegation.
5. How many cases exist in Florida wherein you believe the expert witness provided testimony which is a gross misrepresentation of the standard of care? Please produce any documentation in support of any allegation
6. Please identify those expert witnesses that you characterized as "hired guns."
7. How much would it cost for a defendant to participate in the proposed presuit screening panels? What are those costs attributable to? What is the basis for your calculations?
8. How many notices of intent to litigate did FMA members receive last year? How many of those claims for which a notice of intent to litigate was received resulted in a lawsuit? How many of those claims for which a notice of intent to litigate was received resulted in settlements? How many of those claims for which a notice of intent to litigate was received went to trial? How many of those claims for which a notice of intent to litigate

was received were dismissed? How many of those claims for which a notice of intent to litigate was received resulted in indemnities paid by an insurer on behalf of the physician or paid by the physician? Please provide same for each of the last 5 years.

9. How many non-meritorious lawsuits were filed against FMA members last year? How many non-meritorious lawsuits were filed against FMA members during the each of the last 5 years? 10 years? Please explain how you determined that each lawsuit included in your count was non-meritorious.
10. Please produce a copy of the contract or any other written agreements between the FMA and First Professional Insurance Company (FPIC) that were in effect for any period of time during the last 3 years.
11. Please explain the process that has been used for the last 5 years to place FMA members on the FPIC board and the role that FPIC or its officers or directors play at the FMA. Please explain all benefits provided to these persons, including any direct or indirect remuneration, goods, services, or other benefits provided.

We ask that you please provide the appropriate responsive documentation to the Senate Committee on Judiciary no later than **5:00 pm on Monday, August 4, 2003**. We recognize that Ms. Mortham has already provided an affidavit to the committee that may in part answer these questions. If this is the case, please indicate so in your response. To aid you in your response, we have attached those pages of the transcript that contain your testimony. If you have any questions, please contact Judiciary Committee staff at (850) 487-5198.

Sincerely,

Senator Alex Villalobos
Chair

FLORIDA MEDICAL ASSOCIATION, INC.
P.O. Box 10269 • Tallahassee, Florida • 32302 • 113 E. College Ave. • 32301
(850) 224-6496 • (850) 222-8827-FAX • Internet Address: www.fmaonline.org

August 4, 2003

The Honorable J. Alex Villalobos
Chairman, Senate Judiciary Committee
515 Knott Building
Tallahassee, Florida 32399

Dear Senator Villalobos:

I am in receipt of your letter to Sandra Mortham and Jeff Scott, dated July 29, 2003 in which you ask a number of follow up questions to the carefully controlled, limited testimony you orchestrated at the behest of the trial bar on July 14, 2003. I have taken it upon myself to personally reply on behalf of the 16,328 members of the Florida Medical Association. Your questions ask for a tremendous amount of data. Unfortunately, the FMA does not have the resources to fully respond by your imposed due date. We do, however, assure you that the Judiciary Committee's attempt to call into question the existence of an access to care crisis are misguided and represent a tremendous disservice to the citizens of Florida. If you had attended the meetings of the Governor's Select Task Force or the House Select Committee on Medical Liability Insurance, you would have seen first hand the evidence of the impact this crisis has had on access to care. We invite you to review the reports of both groups for information concerning physicians who have left the state and/or scaled back their practices. In addition, you have the results of a survey we conducted in December of 2002 that elicited over 2,500 responses from physicians who have been impacted by the crisis. Furthermore, we are certain you have received numerous letters, emails and other communications from physicians indicating the seriousness of the crisis.

Since you have recently decided to place a premium on testimony given under oath, we present to you over 1,500 affidavits from physicians licensed in Florida who have attested to either having to quit the practice of medicine or having to scale back their practice due to liability concerns. These affidavits constitute sworn testimony that there are at least fifteen hundred physicians who are no longer providing the same level of care as they were before this crisis began. To say patient access to care has not been affected is to engage in intellectual dishonesty. Statistics can be spun many ways. As Chairman of the Judiciary Committee, we urge you not to hide behind misleading numbers and ignore the evidence of the crisis that does exist.

Sincerely,

Robert E. Cline, M.D.
President
Florida Medical Association

Orcutt

THE FLORIDA SENATE
COMMITTEE ON JUDICIARY

Location
515 Knott Building
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J. Alex Villalobos, *Chair*
Dave Aronberg, *Vice Chair*
Dawn Roberts, *Staff Director*
Senate's Website: *www.flsenate.gov*

July 29, 2003

Diane Orcutt
Deputy Division Director, Florida Dept. of Health
Division of Medical Quality Assurance
4052 Bald Cypress Way, Bin C00
Tallahassee, FL 32399-3250

Dear Ms. Orcutt:

In reviewing the transcript of the Senate Committee on Judiciary meeting on July 14-15, 2003, we have identified several occurrences where you were asked to provide information subsequent to your testimony. Additionally, the committee has identified certain issues for which it requests additional information. Specifically, we request a response in the following instances:

1. Please provide a table indicating, as of July 1, 2003, how many Florida licensed physicians report a Florida address and indicate that they are actively practicing in Florida. Please also include the specialty practice area of these Florida-based physicians.
2. How does Florida compare to other states with similar demographics with regard to the availability of emergency room physicians?
3. How does Florida compare to other states with similar demographics with regard to the availability of obstetrical care, mammography and other radiology services, neurology services, and other specialties?
4. Please provide a table indicating as of July 1, 2003, how many Florida licensed physicians comply with the financial responsibility requirements of Florida law through the purchase of professional liability insurance, through other alternatives, or indicate that they are bare of professional liability insurance. Please break out the choice of alternative methods.
5. Pleaser provide a table indicating the number of "notification of office closings" received by the Board of Medicine for each of the last three years.

We ask that you please provide the appropriate responsive documentation to the Senate Committee on Judiciary no later than **5:00 pm on Monday, August 4, 2003**. To aid you in your response, we have attached those pages of the transcript that contain your testimony. If you have any questions, please contact Judiciary Committee staff at (850) 487-5198.

Sincerely,

Senator Alex Villalobos
Chair

Alex Villalobos, Chair
Committee on Judiciary
The Florida Senate
404 South Monroe Street
Tallahassee, Florida 32399-1100

Dear Senator Villalobos:

In response to your request of July 29, 2003, the following information is provided:

1. A table is attached showing the number of actively licensed allopathic and osteopathic physicians as of August 1, 2003. These numbers are reported by specialty.

2. A chart is attached showing, as of September 2002, the number of physicians practicing in each of twelve selected specialties in Florida with comparisons to California, Texas, and New York. This information was obtained from the American Board of Medical Specialties, which accredits the certifying boards for the reported specialties. (Please note that mammography is not a board-certified specialty.)

3. See same chart provided for Question #2.

4. Attached are charts providing a breakdown of our current information on file for the types of financial responsibility elected by allopathic and osteopathic physicians in Florida.

5. The number of office closings reported to the department to date since January 1, 2000 is 1,146 for allopathic physicians and 27 for osteopathic physicians. This information is self-reported and documented on a note field in the department's database. It is not required that the physician give any reason for the office closing.

Thank you for the opportunity to provide these statistics. If you have any questions about this information, please call Diane Orcutt at (850) 245-4123.

Sincerely,

Diane Orcutt
Deputy Director
Medical Quality Assurance

Specialty Practice Areas Reported by
Licensed Medical Physicians* with Florida Mailing Addresses
Report Date August 1, 2003

Specialty Area	Count
AEROSPACE MEDICINE	3
AI - ALLERGY AND IMMUNOLOGY	174
AI - CLINICAL AND LABORATORY IMMUNOLOGY	7
AN - ANESTHESIOLOGY	1426
AN - CRITICAL CARE MEDICINE	186
AN - PAIN MANAGEMENT	281
AN - PEDIATRIC ANESTHESIOLOGY	7
BEHAVIORAL HEALTH	1
CPP - PEDIATRICS/PSYCHIATRY/CHILD AND ADOLESCENT PSYCHI	25
CRS - COLON AND RECTAL SURGERY	72
D - DERMATOLOGY	523
D - DERMATOPATHOLOGY	98
DIAGNOSTIC IMAGING	8
DR - DIAGNOSTIC RADIOLOGY	397
DR - NEURORADIOLOGY	90
DR - NUCLEAR RADIOLOGY	52
DR - PEDIATRIC RADIOLOGY	33
DR - VASCULAR AND INTERVENTIONAL RADIOLOGY	128
EM - EMERGENCY MEDICINE	891
EM - SPORTS MEDICINE	15
EMP - PEDIATRICS/EMERGENCY MEDICINE	65
ENDOCRINOLOGY REPRODUCTIVE INFERTILITY	7
FAMILY PRACTICE	210
FP - FAMILY PRACTICE	2165
FP - GERIATRIC MEDICINE	182
FP - SPORTS MEDICINE	32
GPM - PREVENTIVE MEDICINE	71
GS - HAND SURGERY	48
GS - PEDIATRIC SURGERY	45
GS - SURGERY	1518
GS - SURGICAL CRITICAL CARE	66
GS - VASCULAR SURGERY	122
IC - INTERVENTIONAL CARDIOLOGY	53
IFP - INTERNAL MEDICINE/FAMILY PRACTICE	18
IM - CARDIOVASCULAR DISEASE	1244
IM - CLINICAL CARDIAC ELECTROPHYSIOLOGY	61
IM - CRITICAL CARE MEDICINE	209
IM - ENDOCRINOLOGY, DIABETES AND METABOLISM	189
IM - GASTROENTEROLOGY	657
IM - GERIATRIC MEDICINE	283
IM - HEMATOLOGY	241
IM - HEMATOLOGY AND ONCOLOGY	58
IM - INFECTIOUS DISEASE	227
IM - INTERNAL MEDICINE	5944
IM - NEPHROLOGY	307
IM - ONCOLOGY	398
IM - PULMONARY DISEASE	492
IM - PULMONARY DISEASE AND CRITICAL CARE MEDICINE	56
IM - RHEUMATOLOGY	199
IM - SPORTS MEDICINE	9
IPM - INTERNAL MEDICINE/PREVENTIVE MEDICINE	1

Specialty Area	Count
MEM - INTERNAL MEDICINE/EMERGENCY MEDICINE	1
MG - MEDICAL GENETICS	22
MN - INTERNAL MEDICINE/NEUROLOGY	1
MP - INTERNAL MEDICINE/PSYCHIATRY	1
MPD - INTERNAL MEDICINE/PEDIATRICS	5
MPM - INTERNAL MEDICINE/PHYSICAL MEDICINE AND REHABILIT	11
N - CHILD NEUROLOGY	34
N - CLINICAL NEUROPHYSIOLOGY	37
N - NEUROLOGY	382
NEURODEVELOPMENT DISABILITIES	1
NEUROLOGY	38
NM - NUCLEAR MEDICINE	207
NPR - NEUROLOGY/PHYSICAL MEDICINE AND REHABILITATION	5
NRN - NEUROLOGY/DIAGNOSTIC RADIOLOGY/NEURORADIOLOGY	209
NS - NEUROLOGICAL SURGERY	190
NULL	2763
NUTRITION	4
OBG - OBSTETRICS AND GYNECOLOGY	1432
OCCUPATIONAL HEALTH	27
OCCUPATIONAL MEDICINE	17
OPH - OPHTHALMOLOGY	944
ORS - ADULT RECONSTRUCTIVE ORTHOPAEDICS	2
ORS - FOOT AND ANKLE ORTHOPAEDICS	2
ORS - HAND SURGERY	36
ORS - ORTHOPAEDIC SPORTS MEDICINE	3
ORS - ORTHOPAEDIC SURGERY	872
ORS - ORTHOPAEDIC SURGERY OF THE SPINE	5
ORS - ORTHOPAEDIC TRAUMA	2
ORS - PEDIATRIC ORTHOPAEDICS	1
ORTHOPEDICS	81
OTHER	224
OTO - OTOLARYNGOLOGY	429
OTO - OTOLOGY-NEUROTOLOGY	1
OTO - PEDIATRIC OTOLARYNGOLOGY	1
P - ADDICTION PSYCHIATRY	73
P - CHILD AND ADOLESCENT PSYCHIATRY	144
P - FORENSIC PSYCHIATRY	62
P - GERIATRIC PSYCHIATRY	83
P - PSYCHIATRY	835
PD - ADOLESCENT MEDICINE	11
PD - NEONATAL-PERINATAL MEDICINE	196
PD - PEDIATRIC CARDIOLOGY	77
PD - PEDIATRIC CRITICAL CARE MEDICINE	56
PD - PEDIATRIC ENDOCRINOLOGY	43
PD - PEDIATRIC GASTROENTEROLOGY	30
PD - PEDIATRIC HEMATOLOGY/ONCOLOGY	41
PD - PEDIATRIC INFECTIOUS DISEASES	33
PD - PEDIATRIC NEPHROLOGY	25
PD - PEDIATRIC PULMONOLOGY	30
PD - PEDIATRIC RHEUMATOLOGY	8
PD - PEDIATRICS	2457
PHYSIOLOGICAL THERAPEUTICS & REHABILITATION	1
PIR - PODIATRIC INTERNSHIP/RESIDENCY	1
PLASTIC SURGERY WITHIN THE HEAD AND NECK	2
PM - PHYSICAL MEDICINE AND REHABILITATION	147

Specialty Area	Count
PM - SPINAL CORD INJURY MEDICINE	2
PMP - PEDIATRICS/PHYSICAL MEDICINE AND REHABILITATION	2
PS - CRANIOFACIAL SURGERY	6
PS - HAND SURGERY	8
PS - PLASTIC SURGERY	404
PTH - BLOOD BANKING/TRANSFUSION MEDICINE	35
PTH - CHEMICAL PATHOLOGY	8
PTH - CYTOPATHOLOGY	114
PTH - FORENSIC PATHOLOGY	62
PTH - HEMATOLOGY	23
PTH - HEMATOPATHOLOGY	1
PTH - IMMUNOPATHOLOGY	11
PTH - MEDICAL MICORBIOLOGY	4
PTH - NEUROPATHOLOGY	22
PTH - PATHOLOGY	120
PTH - PATHOLOGY-ANATOMIC AND CLINICAL	652
PTH - PEDIATRIC PATHOLOGY	7
PYN - PSYCHIATRY AND NEUROLOGY	143
PYN - PSYCHIATRY/NEUROLOGY	7
RADIOLOGY - DIAGNOSTIC	708
RO - RADIATION ONCOLOGY	175
TS - THORACIC SURGERY	294
U - PEDIATRIC UROLOGY	12
U - UROLOGY	544
UNDERSEA & HYPERBARIC MEDICINE	1

* Medical Physicians with Active Licenses

Specialty Practice Areas Reported by
Licensed Osteopathic Physicians* with Florida Mailing Addresses
Report Date August 1, 2003

Specialty Area	Count
AEROSPACE MEDICINE	2
AI - ALLERGY AND IMMUNOLOGY	5
AI - CLINICAL AND LABORATORY IMMUNOLOGY	1
AN - ANESTHESIOLOGY	95
AN - CRITICAL CARE MEDICINE	3
AN - PAIN MANAGEMENT	29
CRS - COLON AND RECTAL SURGERY	1
D - DERMATOLOGY	43
D - DERMATOPATHOLOGY	1
DIAGNOSTIC IMAGING	1
DR - DIAGNOSTIC RADIOLOGY	13
DR - NEURORADIOLOGY	1
DR - VASCULAR AND INTERVENTIONAL RADIOLOGY	1
EM - EMERGENCY MEDICINE	155
EM - SPORTS MEDICINE	4
EMP - PEDIATRICS/EMERGENCY MEDICINE	4
FAMILY PRACTICE	91
FP - FAMILY PRACTICE	838
FP - GERIATRIC MEDICINE	42
FP - SPORTS MEDICINE	4
GPM - PREVENTIVE MEDICINE	9
GS - SURGERY	59
GS - VASCULAR SURGERY	9
IC - INTERVENTIONAL CARDIOLOGY	1
IFP - INTERNAL MEDICINE/FAMILY PRACTICE	2
IM - CARDIOVASCULAR DISEASE	34
IM - CLINICAL CARDIAC ELECTROPHYSIOLOGY	1
IM - CRITICAL CARE MEDICINE	10
IM - ENDOCRINOLOGY, DIABETES AND METABOLISM	2
IM - GASTROENTEROLOGY	29
IM - GERIATRIC MEDICINE	10
IM - HEMATOLOGY	9
IM - HEMATOLOGY AND ONCOLOGY	2
IM - INFECTIOUS DISEASE	2
IM - INTERNAL MEDICINE	290
IM - NEPHROLOGY	6
IM - ONCOLOGY	14
IM - PULMONARY DISEASE	13
IM - PULMONARY DISEASE AND CRITICAL CARE MEDICINE	3
IM - RHEUMATOLOGY	9
IM - SPORTS MEDICINE	2
MPM - INTERNAL MEDICINE/PHYSICAL MEDICINE AND REHABILIT	2
N - CHILD NEUROLOGY	1
N - CLINICAL NEUROPHYSIOLOGY	2
N - NEUROLOGY	23
NEUROLOGY	6
NM - NUCLEAR MEDICINE	12
NRN - NEUROLOGY/DIAGNOSTIC RADIOLOGY/NEURORADIOLOGY	5
NS - NEUROLOGICAL SURGERY	3
NULL	209
OBG - OBSTETRICS AND GYNECOLOGY	65
OCCUPATIONAL HEALTH	8
OCCUPATIONAL MEDICINE	8
OIR - OSTEOPATHIC INTERNSHIP/RESIDENCY	16
OPH - OPHTHALMOLOGY	35
ORS - HAND SURGERY	1
ORS - MUSCULOSKELETAL ONCOLOGY	1
ORS - ORTHOPAEDIC SURGERY	52
ORTHOPEDICS	10
OTHER	23
OTO - OTOLARYNGOLOGY	22
P - ADDICTION PSYCHIATRY	5
P - CHILD AND ADOLESCENT PSYCHIATRY	3
P - FORENSIC PSYCHIATRY	2
P - PSYCHIATRY	33
PD - ADOLESCENT MEDICINE	1
PD - NEONATAL-PERINATAL MEDICINE	6
PD - PEDIATRIC CARDIOLOGY	1
PD - PEDIATRIC CRITICAL CARE MEDICINE	1
PD - PEDIATRIC PULMONOLOGY	2
PD - PEDIATRICS	66
PM - PHYSICAL MEDICINE AND REHABILITATION	23
PM - SPINAL CORD INJURY MEDICINE	1
PS - HAND SURGERY	1
PS - PLASTIC SURGERY	12
PTH - CYTOPATHOLOGY	4
PTH - FORENSIC PATHOLOGY	2
PTH - PATHOLOGY	4
PTH - PATHOLOGY-ANATOMIC AND CLINICAL	21
PYN - PSYCHIATRY AND NEUROLOGY	11
RADIOLOGY - DIAGNOSTIC	39
RO - RADIATION ONCOLOGY	4
SPORTS INJURIES & PHYSICAL FITNESS	1
TS - THORACIC SURGERY	3
U - UROLOGY	14

* Osteopathic Physicians with Active Licenses

Questions #2 & 3

Comparison of Numbers of Certified Medical Specialists for Selected Specialties*

Specialty	Total US	FL	CA	TX	NY
Anesthesiology	33,413	1,968	4,107	2,324	2,654
Emergency Medicine	27,968	1,542	4,214	1,222	1,529
Family Practice	71,862	2,968	7,221	4,501	3,169
Internal Medicine	176,594	9,070	20,169	8,951	19,401
Neurology	9,982	551	1,117	561	1,034
Neurological Surgery	4,259	266	493	281	281
Obstetrics/Gynecology	61,003	3,222	6,653	3,955	5,035
Orthopedic Surgery	25,999	1,578	3,308	1,536	1,722
Pediatrics	84,880	4,320	10,072	4,995	8,757
Radiology	38,237	2,284	4,405	2,312	3,239
Surgery	50,928	2,907	5,275	3,104	4,029
Thoracic Surgery	8,790	657	982	600	602

Populations - 2000 Census	
FL	15,982,378
CA	33,871,648
TX	20,851,820
NY	18,976,457

*Figures from American Board of Medical Specialties, September 2002

Financial Responsibility Reported by
Licensed Medical Physicians* with Florida Mailing Addresses
Report Date August 1, 2003

Reported Financial Status	Reported Financial Exemption	Count
Irrevocable Letter of Credit $100,000		112
Irrevocable Letter of Credit $250,000		332
Liability Under $100,000		2682
Liability Under $250,000		24106
Not Carrying Medical Malpractice	No exemption reported	2132
Exemption reported	Government	3111
Exemption reported	Limited License	23
Exemption reported	Not Practicing in Florida	987
Exemption reported	Other Criteria	2379
Exemption reported	Teaching	924
TOTAL		36788

* Medical Physicians with Active Licenses

Financial Responsibility Reported by
Licensed Osteopathic Physicians* with Florida Mailing Addresses
Report Date August 1, 2003

Reported Financial Status	Reported Financial Exemption	Count
Irrevocable Letter of Credit $100,000		21
Irrevocable Letter of Credit $250,000		75
Liability Under $100,000		354
Liability Under $250,000		1927
Not To Carry Medical Malpractice	No exemption reported	118
Exemption reported	Government	170
Exemption reported	Limited License	7
Exemption reported	Not Practicing in Florida	162
Exemption reported	Other Criteria	197
Exemption reported	Teaching	26
TOTAL		3057

* Osteopathic Physicians with Active Licenses

THE FLORIDA SENATE
COMMITTEE ON JUDICIARY

Location
515 Knott Building
Mailing Address
404 South Monroe Street
Tallahassee, Florida 32399-1100
(850) 487-5198

J. Alex Villalobos, *Chair*
Dave Aronberg, *Vice Chair*
Dawn Roberts, *Staff Director*
Senate's Website: *www.flsenate.gov*

July 29, 2003

Gail Parenti
Parenti, & Falk
113 Almeria Ave.
Coral Gables, FL 33134

Dear Ms. Parenti:

In reviewing the transcript of the Senate Committee on Judiciary meeting on July 14-15, 2003, we have identified several occurrences where you were asked to provide information subsequent to your testimony. Additionally, the committee has identified certain issues for which it requests additional information. Specifically, we request a response in the following instances:

1. Please provide the number of medical malpractice claims that have originated in the emergency room in each of the last ten years.
2. Would this number change once the patient is stabilized and sent to surgery, or intensive care etc, and the malpractice occurred after stabilization?
3. How many companies sell hospital professional liability insurance?
4. In order to secure the consultants and the back-up doctors to support the emergency room physicians, do hospitals pay those consultants and back-up doctors that have clinical privileges at that hospital to be on call? Do these hospitals require those consultants and back-up doctors with clinical privileges to provide back-up support?

We ask that you please provide the appropriate responsive documentation to the Senate Committee on Judiciary no later than **5:00 pm on Monday, August 4, 2003**. To aid you in your response, we have attached those pages of the transcript that contain your testimony. If you have any questions, please contact Judiciary Committee staff at (850) 487-5198.

Sincerely,

Senator Alex Villalobos
Chair

JAMES E. "JIM" KING, JR.
President

ALEX DIAZ DE LA PORTILLA
President Pro Tempore

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KHRISTEN S. VACHAL
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August 4, 2003

Senator J. Alex Villalobos
The Florida Senate
Committee on Judiciary
404 South Monroe Street
Tallahassee, Florida 32399-1100

Dear Senator Villalobos:

I received your letter dated July 29, 2003, asking for additional information concerning my testimony before the Senate Committee on Judiciary on July 15, 2003. With all due respect to you and the Committee, I answered each of the questions outlined in your letter, under oath, to the best of my ability at the time of my testimony, based upon my own limited understanding and awareness.

Please understand that I am an appellate attorney. I study legal issues. As a participant in this process, and specifically as a lobbyist on behalf of the Florida Hospital Association, I have been called upon from time to time to provide input and education on legal issues; e.g., set-offs, voluntary binding arbitration, and the proposed elimination of the *Fabre* rule. I have come to realize that my role is somewhat unique, in that there are not many practitioners from the defense side who are willing and able to devote the time away from their practice required to participate in the legislative process in a meaningful way.

I do not believe that I have made factual claims or assertions which require, or are even capable of, extrinsic "proof." What I have said, from the time I was asked to testify before the Governor's Select Task Force, is that there are certain aspects of the current law which no longer make sense, and need to be addressed in order to achieve meaningful litigation reform. These include the need to reform the set-off statutes, which have not been amended in over twenty years; the need to preserve and strengthen the presuit screening process, including voluntary binding arbitration; and the need to ensure that each defendant pays only his or her share of fault.

In this regard, I do believe I am able to provide some insight as to questions which were asked of other witnesses about "language" submitted to the Governor's Select Task Force. The Committee did not ask me about this issue, but I drafted some language which was submitted to

the Governor's Select Task Force, a version of which was eventually included in the original SB 564. At the outset, I would note that there appeared to be some misapprehension on the part of the Committee in terms of "language." The Governor's Select Task Force report did not include specific language to implement its recommendations.

In the late summer or early fall of 2002, I was contacted by Bill Bell, general counsel for the Florida Hospital Association, and asked if I would be willing to draft proposed legislation on reforms which I felt would be fair, but would also stabilize the insurance market. At that time, I was not even aware that a Task Force had been named. It is my understanding that Mr. Bell was provided our firm's name as a firm with experience in the medical malpractice area. I provided Mr. Bell with an article I had written which called for legislative reform in the area of voluntary binding arbitration, and subsequently provided him with other language which I felt represented fair reforms which would stabilize the insurance market. These proposals included language for proposed amendments relating to set-offs, collateral sources, comparative fault, presuit screening and voluntary binding arbitration, hospital liability, the definition of "reckless disregard" for purposes of the Good Samaritan Act, and permissible forms of proof of medical expenses.

Thereafter, I was invited to testify before the Governor's Select Task Force on November 22, 2003. I was asked to speak on the issues of voluntary binding arbitration and comparative fault. Because of the inter-relationship of the issues of comparative fault and set-off, there was some discussion of which witness would address which issue. In conjunction with discussions with William Large on the matter of finalizing the agenda, I emailed copies of the proposed language I had previously drafted pertaining to set-offs, collateral sources, and comparative fault, to illustrate the changes which I believed needed to be made, and the issues I would be prepared to discuss at the upcoming Task Force meeting. When I testified before the Task Force on November 22, 2002, I referenced and explained the specific proposals for legislative change that I had provided in conjunction with my anticipated testimony relating to set-offs, collateral sources, and comparative fault. I enclose herewith a copy of the transcript of that testimony, wherein I spoke of the fact that I had not only provided language for a proposed change to the set-off statute, but explained the basis for the change I advocated.

At the time of my testimony before the Task Force, I was speaking on my own behalf as a defense attorney with experience in the area of medical malpractice, and ideas on changes that needed to be made to the litigation system to bring about stability in the insurance market. I had not yet been retained by the Florida Hospital Association. I trust this explanation puts to rest any questions the Committee has on the issue of "language" submitted to the Task Force on the issue of set-offs in particular.

After SB 564 and HB 1713 were filed, I recognized that the language which I had originally proposed could be interpreted in a manner which was inconsistent with what I had intended. During the course of the regular session, I discussed the issue of set-offs with Senator Smith on several occasions, and together we drafted language which more clearly expressed and

refined the intent of the set-off reform I had proposed, and still believe is necessary. That language, with one substantive change, appears in HB 15C.

Since I do not have personal knowledge sufficient to answer the questions stated in your letter, I did pose your questions to the Florida Hospital Association. I was able to obtain the following additional information for the Committee's consideration:

1. Milliman USA actuaries looked at this issue for the Florida Hospital Association and after looking at the Florida Department of Insurance closed-claim data base, found that Emergency Room cases make up about 10% of claim counts and dollars. Milliman notes that while the 10% pertains to claims which originated directly from the E/R, there may be additional related claims which apply to treatment in other areas, (e.g. surgery) after leaving the E/R. Thus, the true percentage of claims attributable to E/R treatment may be understated. Also, because the closed-claim data base does not require everyone to report, the total number of claims and total number of dollars may also be understated.

The Milliman Report, dated November 7, 2002, was provided to the Governor's Select Task Force, and to the House Select Committee. In addition, Dick Biondi testified on June 24, 2003, at the Senate Workshop, and on November 22, 2002 before the Governor's Select Task Force. We would refer you to the report itself, a copy of which is attached, as well as to Mr. Biondi's prior testimony. The report and Mr. Biondi's testimony would address the limitations inherent in evaluating the closed-claim data base, and thereby explain why a more specific answer to your question is not possible in light of the data currently available.

2. Please see above answer.

3. Hospitals have reported to the FHA that they are having a difficult time finding affordable liability insurance. Insurers are offering lower limits of coverage but requiring hospitals to carry higher retention levels. It is our understanding that more hospitals, if not most, are being forced to self-insure for greater limits and take on more risk. A couple of years ago, there were about six insurers. Today, we know St. Paul has left the state and have heard that most of the remaining carriers are only writing excess coverage. It is not unusual for hospitals to be self-insured for limits of $1million, $3million, $5million, and up.

4. Both federal and Florida law require hospitals with emergency rooms to provide on call physician specialists. Because of lack of specialists in the current environment, hospitals are having an increasingly difficult time finding specialists to serve on call. The FHA has not collected data on the payment by hospitals to on call specialists in emergency rooms, although it has recently been reported that some hospitals have found the need to do so in order to ensure the availability of on call specialists. Since FHA has not collected the data, however, it is not possible to provide a more detailed response to your question, particularly since the response may be different as to each individual hospital or hospital system.

Finally, I feel compelled to express my objection, in the strongest terms, to the manner in which the Senate Judiciary Committee conducted the taking of testimony on July 14 and 15, 2003. The Committee identified specific witnesses, myself included, who were "invited" to testify under oath, and to respond to questioning. Other stakeholders were not "invited" to testify, even though they had made specific claims about the role of "frivolous lawsuits" in the current crisis. There was no advance indication of what areas of questioning these selected individuals might expect to face; no ability to judge whether the individual selected by the Committee would be in a position to have knowledge of the matters about which they would be asked to provide information; no opportunity for the individual witnesses to make a statement, before or after questioning; no opportunity to object to leading and often condescending, if not downright insulting, questions, and no opportunity to present evidence in rebuttal. Yet, these witnesses have been taken to task by members of the Senate, and by the media, for failing to "prove" their claims.

Had the involved stakeholders been asked to "prove" claims in a *genuine* fact finding mission, they would have been given advance notice of what it was they were expected to "prove." They would have also been given an opportunity to present evidence through other witnesses as needed, not just those identified by the Committee, and that evidence would not have been limited to responses -- frequently interrupted -- to scripted, often misleading, questioning by hostile interrogators. Statements made by various Senators to the effect that witnesses could not prove their claims is like declaring victory after hearing only one side of the opening statement in a trial. Fair-minded people cannot characterize the product of such a fundamentally unfair proceeding as anything remotely resembling the truth.

Once again, I thank you for the opportunity to be heard in this important debate.

Very truly yours,

Gail Leverett Parenti

GLP
enclosure

group of five, six, seven doctors in a hospital on the case and once all the ones that feel that they have more culpability have settled out and you're the last indian standing and you really believe you're innocent, the plaintiff has no downside risk whatsoever to going to trial against you because they're going to collect from dollar one. That's the problem that we have.

And to me, it is the most serious issue that faces the panel. I'm not trying to say these other issues aren't important, but I think this is the single biggest problem that we have under our law today.

And with that, I'll let Ms. Parenti talk more on this subject.

MS. PARENTI: I want to add a little different perspective to the same problem. And that has to do with the interrelationship of nursing home litigation and malpractice litigation. As I said, I especially represent hospitals and what we've being -- what we've seen happen recently, and I actually alluded to it in the arbitration discussion, that is the fragmentation of the wrongful death remedy.

Ever since the Supreme Court -- ever since the District Court of Appeal held that you can get different damages for wrongful death in the nursing home case than you can in the hospital case, what we see in almost every single case is multiple lawsuits being filed against thre or four different nursing homes and then against two or three different hospitals and it's the same bedsore. You have them go from a nursing home into a hospital into another nursing home into a rehab facility and it's the same injury going through across.

But the claim is, once you get into litigation, there's no set-off because I have different damages that are available under Chapter 400 than are available under the general law and under -- against the hospital.

So we have a compounding of the problem that Mr. Hurt has just addressed. It becomes increasingly difficult to apply the set-off laws. And it really is a problem because you have a situation where, you know, you're the hospital and they've already settled with four different facilities or hospitals and gotten two million dollars and they're still coming after

you and claiming that you owe from dollar one.

I have provided several different proposals and these issues are very interrelated, but the common theme, I believe, in all of them is trying to eliminate a duplication of recovery where it's possible to do that fairly. And it really has to do with fairness.

The first specific proposal is an amendment to the statute that relates to set-offs and there are actually two statutes that are identical, but the statute I've provided is 46.015 and the specific proposal, first off, would be to clarify that a set-off is available in arbitration. If a defendant offers to admit liability and goes to arbitration and there is somebody else that's already settled, there ought to be a set-off there, too.

But, also, I wanted to specifically address the Goudi case with language that would say that a set-off is available regardless of whether a jury ultimately determines that the settling defendant is at fault, which alleviates the problem of the party having to go in to prove the fault of a non-party or a settled party, when all they want is a set-off. They shouldn't

have to do that.

If they want to actively reduce their exposure by putting percentages on that party, that's one thing. But just to get the set-off, you should have to have the burden of hiring experts and putting on proof that the settled party was negligent. So that would be a specific proposal.

The second and last proposal as far as amending the statute as far as set-offs would be to try to give us some ability to deal with the nursing home versus hospital situation and say that, regardless of the theory of liability, if it's -- if it's basically the same damages, you get a set-off dollar for dollar.

The second proposal that I have that relates to this specific issue is one that, again, it's all related and one of the problems you have in that case where the plaintiff has gotten two million dollars from other settled defendants and now going to trial against the last indian or last hospital, is that the plaintiff then is allowed, under the current law, to say, you know what, those parties I took two million dollars from, they're not liable.

That's wrong.

I would propose that the comparative fault statute be amended so that if a plaintiff has accepted money from a settled party, he is estopped to deny that that party was negligent. It's up to the defendant if they want to put on evidence to show that that party is more liable than they are, but they cannot have the claimants coming in and taking two million dollars from settled defendants and then turn it around and then talking out of the opposite side of their mouth and saying that that party wasn't negligent.

So that's a fairness consideration and consistent with the law of judicial estoppel. The other proposal with regard to comparative fault, which I know is going to create a fire storm, is elimination of joint and several for economical damages. And this is something that hits hospitals acutely, especially in cases where there is minimal liability on the hospital, but there's significant care issues. If it's an injured baby or someone who's in a coma that requires long-term care, the hospital can be one percent liable and it's absolute

extortion to say that even though they're one percent liable, they are jointly and severely liable for ten or fifteen million dollars in economic damages.

Finally, the other issue that I would offer as a specific proposal in dealing with just the duplication of benefits. It has to do with the collateral source rule.

The first proposal would be to include future collateral sources as available collateral sources so that future economic damages can be set off by future collateral sources. That is the rule that is applicable currently in arbitration. The Supreme Court has said you can do it if you do it specifically and we would propose that that be the case to eliminate that element of duplication.

The other has to do with case where right of subrogation exists in terms of health care benefits. The current Collateral Source statute provides that there is -- and I have to get this straight. There is no set-off if there's a right of subrogation.

In other words, if the plaintiff has to pay back the medical expenses, then the defendant

doesn't get to set that off. If the plaintiff has to pay it back, then the defendant's not entitled to get a set-off.

Well, what we've seen in a couple of appellate decisions is situations where, by one mechanism or another, the plaintiff compromises or obtains an agreement from the person who holds that subrogation right that is waived. So now the plaintiff is in a situation where they don't have to pay back that $400,000 in medical expenses, but yet they're still entitled to claim that $400,000 from the defendant.

The way that the court has looked at it is, well, if the subrogation right existed at the time of the injury, then that's what we're going to go by. It doesn't matter what the plaintiff does later on. We would suggest that the appropriate viewpoint is whether or not a subrogation right exists at the time of judgment. At the time the money has to be paid, does the plaintiff have to pay that money back to the health care provider? And, if so, the defendant has to pay it.

If at that time the plaintiff doesn't have to pay it back, then the defendant shouldn't

have to pay. All we're talking about is reduction of double damages and duplication of benefits and those are the specific proposals that we would offer on those issues.

Thank you.

CHAIRMAN HITT: Thank you, Ms. Parenti.

Mr. Perwin, are you ready to proceed?

MR. PERWIN: Yes, Mr. Chairman.

On this whole question of set-off and joint and several liability, the common law doctrine of set-off arose as an analog to joint and several liability. Under the common law, a defendant found liable was jointly and severally liable for all of the damages and he had a right of contribution against anybody else who was liability for any of the damages so that there would be fairness and he would only pay his share.

If the plaintiff had settled already with one of those people, then he had a right to a set-off against what he was supposed to pay, so there wouldn't be a double recovery. That was the system and it worked real well.

That system was abolished by the Florida legislature when it removed the doctrine of

FLORIDA HOSPITAL ASSOCIATION

MEDICAL MALPRACTICE ANALYSIS

NOVEMBER 7, 2002

Prepared by:

Richard S. Biondi, FCAS, MAAA
Arthur Gurevitch, PhD
David S. Wolfe, ACAS, MAAA

INTRODUCTION

Milliman USA, Inc. (Milliman) was engaged by the Florida Hospital Association (FHA) to assist their evaluation of potential legislative solutions to the medical malpractice problem in Florida. The goals were to provide an objective evaluation of the medical malpractice problem in Florida and formulate recommendations for changes that we expect to be most effective in addressing the problem. This report documents our findings. We will be happy to answer any questions regarding our analysis.

BACKGROUND INFORMATION

We note that in a report prepared in 1994 by the American Academy of Actuaries, it was noted that a package of tort reforms is more likely to achieve savings in medical malpractice insurance premiums than one or two tort reforms. Specifically, that report highlighted both caps on non-economic damages and mandatory recognition of compensation from collateral sources as two key components of an effective tort reform package. We understand that for Florida, a claimant's damages must be reduced by the amounts paid to the claimant from certain collateral sources[1].

Damage Caps

It is widely viewed that caps on non-economic damages are the most effective reform measure to help control escalating medical malpractice costs. Non-economic damages are generally considered to include compensation for pain and suffering. Florida law currently provides for caps on non-economic damages in a relatively small percentage of cases through its voluntary binding arbitration process. (i.e., where the defendant admits fault and offers to permit the amount of damages to be determined by arbitration. Non-economic damages are capped at $350,000 when the claimant refuses the defendant's offer to arbitrate and $250,000 plus attorneys fees if claimant agrees to arbitration).

An attempt to apply non-economic damage caps across a broader spectrum of cases is likely to be challenged in the Florida court system. Though statutes related to damage caps have been upheld in several states, we note that some states have found such statutes to be unconstitutional (examples are Ohio, Illinois, and Washington). In Texas, the original statute that limited damages to $500,000 (with annual adjustments for inflation) was intended to apply to all medical malpractice cases, but was held to be unconstitutional except with respect to wrongful death cases. Four issues that relate to the effectiveness of a cap on non-economic damages are:

a) the cap limit,
b) whether the cap is indexed for inflation,
c) how the cap applies across defendants, and
d) the number of exceptions to the cap

[1] Damages are reduced by first party insurance benefits. Other sources, such as payments from suits against other defendants may not reduce damages in Florida.

Obviously, the stronger each of these conditions is, the greater the likelihood of reductions in losses and/or premiums. However, as noted in the American Academy of Actuaries report, poorly constructed reforms will not result in lower medical malpractice losses and premiums and may increase costs. Recently, Nevada has enacted a $350,000 cap on non-economic damages, though caps of $500,000 and $750,000 had been discussed by the Nevada legislature. Several exemptions to the cap were initially proposed, but we understand the cap will not apply in cases of gross negligence and cases with clear and convincing evidence of exceptional circumstances. Mississippi has also recently passed a law that caps non-economic damages to $500,000. This cap is scheduled to increase to $750,000 in 2011 and $1,000,000 in 2017. We understand that this cap does not apply to cases where the judge determines that a jury may impose punitive damages. We also understand damages for disfigurement are not included in the cap.

Milliman has performed an analysis of the impact of proposed caps on non-economic damages in New York. Based on this analysis, we have estimated the following percentage savings:

Estimated Savings on Medical Professional Liability
Losses and Loss Adjustment Expenses

Limit on Non-Economic Damage Award	Primary Limits of Coverage $1,000,000/$3,000,000	Excess Limits of Coverage $1,000,000/$3,000,000 XS $1,000,000/$3,000,000
$250,000	29%	59%
500,000	20%	42%
750,000	14%	32%
1,000,000	11%	26%

We note that the results of this analysis are intended to apply to physician's malpractice. We expect that hospital losses and loss adjustment expenses would also be reduced substantially, although the effect may be different for hospitals than for physicians. Hospital claims tend to be somewhat smaller than physicians' claims (which would reduce the effect of a cap). However, hospital claims tend to involve more co-defendants than physician claims (which would increase the effect of a cap). As is discussed below, the data that we have evaluated indicates that a large percentage (i.e., well above 50%) of total loss amounts correspond to non-economic damages versus economic damages, both for physician claims and for hospital claims. This implies that caps on non-economic damages would effectively reduce total losses for both physicians and hospitals.

If legislation is enacted to cap non-economic damages, it is possible that other systemic or behavioral changes will occur to counter the predicted reduction to losses. For example:

1) It is possible that jury awards and settlements for economic loss will increase to partially offset the cap on non-economic loss, or that the percentage of defense verdicts will decline,

2) Legal arguments might be devised to narrow the types of damages subject to the cap, or to define new forms of damages that are outside the limitations on non-economic loss,

3) It is possible that certain types of lawsuits or damages may be exempted (either by statute or court decision) from the award cap,

4) Greater care might be taken by plaintiffs to carefully define and fully list all elements of economic loss, if the possibility no longer exists to use non-economic losses as a catchall for ill-defined damages.

Our analysis of estimated percentage savings was based upon the assumptions that the above events will not occur.

The strongest argument that can be made in favor of caps on non-economic damages is that it has appeared to work so well in California since 1975. California law prescribes a $250,000 cap on non-economic damages and malpractice losses per physician are much lower than the countrywide average (i.e., about 50% of the countrywide average from 1991 to 2000). Thus, there appears to be clear evidence that a cap would be effective in reducing the cost of medical malpractice claims.

OBSERVATIONS/CONCLUSIONS

- Florida medical malpractice paid losses rose over 150% between 1991 and 2000, including a 28% increase from 1999 to 2000.
- During 2000, medical malpractice paid losses per physician were 50% higher in Florida than the countrywide average.
- Florida medical malpractice insurance premiums are over 50% above the countrywide average.
- Florida medical malpractice paid loss dollars per unit of population increased 8.7% per year from 1991 to 2000.
- Non-economic damages, i.e., pain and suffering, comprise approximately 77% of medical malpractice loss payments for Florida hospitals.
- Medical malpractice claim frequency, i.e., number of claims closed per 100,000 population, has increased 57% in Florida over the 9-year period 1991-2000. Florida claim frequency increased about 14% from 1999 to 2000.
- During 2000, Florida claim frequency per physician was higher than every state except PA, MT, NV and WV, and 36% above the countrywide average.
- During 2000, Florida malpractice losses per physician were higher than every state except PA, MT, NY, NV, DC and WV and 50% above the countrywide average. California losses per physician are less than 50% of the countrywide average.

The above conclusions from our analysis are described in more detail in the following sections of this report. They paint a bleak picture for Florida, but we believe it could get worse in the coming years if no corrective action is taken. We know that, in 2002, medical malpractice awards are increasing in severity to record levels throughout the U.S. Claim frequency also appears to be increasing and medical malpractice insurance premiums continue to rise throughout the U.S. Many insurers and reinsurers have left or are leaving the medical malpractice insurance market, creating severe availability problems in many states. Medical malpractice insurance premiums may become unaffordable and/or coverage may become unavailable at any price to many physicians and hospitals.

In Florida, we understand that some physicians and hospitals have reduced their limits of medical malpractice insurance coverage, and some have become uninsured, due to the high cost of such coverage. Some hospitals choose self-insurance or other market mechanisms in an effort to save premiums, at the risk of under-funding their exposure.

One of the primary drivers of the current medical malpractice crisis is that a large percentage of medical malpractice losses (77% in Florida) apply to non-economic damages, i.e., pain and suffering. Pain and suffering is subjective in nature, in that it can't be tied to actual costs incurred by injured patients. Every new record award sets a new higher value on pain and suffering, and precedents keep getting established for higher valuations on all future awards and settlements.

We believe that caps on non-economic damages are particularly effective because they limit the escalation of awards for pain and suffering, which fuels large increases for all awards and settlements. The impact of a cap on non-economic damages would be an immediate savings and a tempering of one of the primary components of future loss trends. Non-economic damage caps seem to have worked extremely well in California, where medical malpractice costs are about 50% of the countrywide average. We feel that this is the strongest evidence that caps on non-economic damages, if there are no large loopholes and exceptions, are the most effective tort reform.

ANALYSIS

Our goal in the remainder of the report is to provide factual information and analysis which defines and quantifies the nature and scope of the medical malpractice problem in Florida. With the FHA, we have formulated a list of 9 relevant questions to be addressed. These are summarized below and individually addressed in the remainder of the report:

What is the historical average annual increase in loss payments/expense for medical liability claims?

What is the historical average annual increase in premiums for the same period?

How are those increases broken down between economic damages, non-economic damages and defense costs?

How are economic damages broken down between wages and medicals and how do those increases compare to the inflation index for wages and health care? Is there any way to tell if economic damages and defense costs are growing faster than non-economic damages?

What are the historical trends on frequency of claims? What would they be when population growth is factored?

What kinds of comparisons can be made between South Florida and North Florida in terms of claims data, premiums, frequency, etc.?

How much of the premium dollar goes to plaintiff's attorney's, defense attorneys, defense costs, claimant, underwriting costs/profit?

What are the average payouts per state?

What % of claims arises out of the emergency room including any subsequent surgery?

DATA SOURCES

Below, we list and describe our data sources used to address the above questions:

Florida Department of Insurance Medical Malpractice Closed Claim Database

The data we received from the Florida Department of Insurance (Florida DOI) was provided in two databases: "Archive" and "Current". The "Archive" database contains claims closed prior to 6/25/99. The "Current" database consists primarily of claims closed between 6/25/99 and 4/30/02. This database also includes a relatively small number of claims with closing dates prior to 6/25/99. The databases contain only closed claim data; there is no provision for pending cases.

An adjustment was required to the data in the Current database to avoid double counting duplicate records in cases involving multiple defendants. For example, a $1 million case against a hospital and three physicians would be included in the Current database as four records (one for the hospital and one for each physician) with *each* showing a settlement of $1 million. We adjusted this database by removing duplicate records on multiple entry claims to obtain a more accurate claim count and loss amount. This issue does not apply to the Archive database as each case appears to be represented by a single entry.

Additionally, we have found that the Current database is limited to claims that are closed with an indemnity payment (e.g., a settlement amount or verdict paid to the injured party) while the Archive database also contains cases closed without indemnity payments. Given this inconsistency, we confined our analysis of this data to claims closed with an indemnity payment.

The Florida DOI database contains and distinguishes claims filed against hospitals and physicians, and so we were able to analyze each separately. Furthermore, there was a lot of other information available from the Florida DOI database that was not available from other sources, such as subdivisions of claim amounts between economic and non-economic losses. The Florida DOI database was our best source of data for Florida hospitals.

National Practitioner Data Bank Public Use Data File

The National Practitioner Data Bank (NPDB) Public Use Data File contains selected variables from medical malpractice payment reports on physicians, dentists, and other licensed health care professionals. It also includes reports of adverse licensure, clinical privileges, professional society membership, and Drug Enforcement Administration (DEA) reports (adverse actions), and Medicare and Medicaid exclusion actions taken by the Department of HHS Office of Inspector General. The NPDB is maintained by the U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Division of Quality Assurance.

The NPDB has been collecting information on cases closed since September 1, 1990. Claims data are collected from all states, so this database provides a rich source of information for geographical and temporal analyses. We obtained the Public Use Data File with data through 4/30/01.

The NPDB Public Use Data File contains information on "physician" claims only. There is no information collected on medical malpractice actions against hospitals or other entities. Further, reports are submitted to the NPDB only when a payment is made. Therefore, there is no information on either pending claims or claims closed without an indemnity payment. We limited our NPDB analysis to medical malpractice claims (by eliminating adverse event reports) against physicians (by eliminating claims against dentists, chiropractors, nurses, etc).

The NPDB data are expressed on a slightly different basis than the Florida DOI database described above. Because information is collected on a per physician basis, the value of each "claim" (in a multiple defendant case) is limited to each physician's share. Thus, a $2 million claim that involves two physicians each apportioned a 50% share would appear as two $1 million claims in the NPDB. Moreover, reports are made to the NPDB by each paying entity, so that if, for example, a primary insurer covers the first $1 million per claim and an excess insurer covers amounts over the first $1 million, a $1.5 million case will appear as two claims: a $1 million (primary) claim and a $500,000 (excess) claim. In the Florida DOI database, the same case would appear once as a $1.5 million entry.

This structural difference between the NPDB and Florida DOI databases will cause differences in the perceived level of average claim severity (i.e., the Florida DOI severity will appear higher because multiple defendant claims will be counted as single large claims, while they will be separated into defendant components in the NPDB database). However, the trends measured from both databases should be consistent and the total number of dollars of loss should be approximately the same.

The Texas Department of Insurance Closed Claim Databases (Texas DOI)

This database contains information on commercial liability closed claims involving bodily injury settled under Texas law with indemnity payments over $10,000. The database includes the following lines of insurance: General Liability, Medical Professional Liability, Other Professional Liability, Commercial Automobile Liability, and the liability portion of Commercial Multi-peril. We obtained a database with claims closed between 1/1/1990 and 12/31/2000.

Texas DOI reports information on a "per claim" basis so that a lawsuit involving several physicians appears as single entry with the indemnity loss being the total value of the case. Texas DOI distinguishes between physician and hospital cases.

PIAA Claim Trend Analysis

The Physicians Insurers Association of America (PIAA) is a national organization of physician-owned companies formed to provide a medium for information exchange and problem solving. The PIAA sponsors a Data Sharing Project, which has detailed data on over 170,000 medical and dental malpractice claims and publishes "Claim Trends" using information reported to the PIAA Data Sharing Project.

Twenty PIAA member companies from across the country participate in the Data Sharing Project. Because this is not a complete (or random) collection of countrywide data, the results are not necessarily reflective of the country as a whole. Nevertheless, PIAA data accurately reflect general medical malpractice trends.

The PIAA only collects information on closed physician cases and, like the NPDB, information is collected on a per physician basis, limiting the value of each "claim" (in a multiple claimant case) to each physician's share. The PIAA does collect detailed and reliable data on cases closed without indemnity loss payments.

We used PIAA data from the Claim Trend Analysis 2000 Edition.

Annual Statements and Rate Filings

Insurance companies provide specific financial, premium, and claims information as part of their Annual Statements. This information is limited to licensed insurance companies (losses reported by self insurance programs are not reported) and detailed claim-by-claim data are not available. Annual Statement data are consolidated for research purposes by Thomson Financial Company. We used Annual Statement data to estimate total premium and overall insurance rates.

Rate filings contain manual rates charged by individual companies for specific specialties and territories. We obtained rate filings for several Florida medical malpractice carriers as well as the Insurance Services Office (ISO) and also used summarized rate information published in the Medical Liability Monitor.

Other Data Sources

Consumer Price Indices were compiled by the United States Bureau of Labor Statistics.

Census Data were compiled by the United States Census Bureau.

Numbers of physicians per state were compiled by the American Medical Association, Chicago, IL., (copyright) in Table 187, Statistical Abstract of the United States, 2000.

RESPONSES TO QUESTIONS

Question 1:

What is the historical average annual increase in loss payments/expense for medical liability claims?

Total Loss Payments
Over the past 10 years, total paid losses (as reported to the NPDB), both countrywide and for Florida, have increased dramatically. The total amount paid out both in Florida and countrywide in 2000 appears to be 150% (FL) and 80% (CW) more than the annual amount paid out a decade earlier (Exhibit 1a). Florida losses are now in excess of $400 million per year with hospital losses accounting for about 38% of total losses (Exhibit 1b). Details of the losses are included in Attachments 1a-c for Florida, PIAA, and NPDB databases (respectively).

The NPDB data indicate more rapid growth of losses in Florida than in the entire U.S. (Exhibit 1a). Florida physician payments reported to the NPDB grew from about $120 million in 1991 to over $300 million in 2000. This reflects an average annual growth of 10.8%. In comparison, countrywide physician payments reported to the NPDB grew at a rate of 6.8% during the same period and were over $3.8 billion in 2000 (see also, Attachments 10 a-d).

Average Loss Payments
Exhibit 1c shows the average paid loss (severity) for medical malpractice claims since 1975 in Florida and countrywide. Four graphs are shown:

1. Florida DOI Hospitals average severity
2. Florida DOI Physicians average severity
3. PIAA Physicians average severity (countrywide)
4. Florida NPDB Physicians average severity

A more detailed examination of NPDB data (Exhibit 1d) shows that through 1996, Florida had a higher claim severity, but a lower severity trend, than the countrywide average. From 1997 through 2000, NPDB data indicate that Florida's severity and severity trend mirror the U.S. as a whole (see also, Attachments 10a-d). Note also that claim severity growth was quite high during 1999 and 2000.

When adjusted for differences in the physician population, the "pure premium" (losses per physician) for Florida physicians is higher than the countrywide average and has grown from 15% above average in 1991 to 50% higher in 2000 (Exhibit 1e).

Defense Costs
Exhibit 1f, and Attachments 1d-e, show defense costs for Florida and PIAA cases (the NPDB does not capture expense costs). Florida hospitals and physicians have historically paid more than PIAA cases on a per case basis for defense costs. However, Florida average defense costs peaked in the mid 1990s and have remained fairly level since then while PIAA countrywide physician defense costs continue to increase at an annual rate of nearly 6%.

Question 2:

What is the historical average annual increase in premiums for the same period?

Since 1996, the total written premium (reported in insurance company Annual Statements) for medical malpractice insurance coverage in Florida increased 64%, to nearly $650 million, while the total U.S. written premium increased 26%, to nearly $7.6 billion (Exhibit 2a, Attachment 2a). Note that these amounts represent commercially insured, filed written premium; self-insurance, off shore captive, and international premiums are not included in these totals. A significant amount of this growth appeared between the last two years of available data (2000-2001), though Florida's continuous growth contrasts with several relatively flat years for the entire U.S.

As a comparative index of medical malpractice insurance rates, we divided the total[2] written premium by the number of physicians (Exhibit 2b, Attachment 2a). Florida's rate is over 55% greater than the countrywide average ($16,424 vs. $10,373 in 2001).

The specific insurance rates for Florida physicians, compiled from selected insurance companies and states, are substantially higher than comparative rates in New York, California and Texas. Moreover, between 1995 and 2002, Florida rates have increased dramatically faster than the rates in those states. (Exhibit 2c, Attachments 2 b-e). The increase in Florida has been even more dramatic during the past two years; the FPIC rate for internal medicine in Dade County increased 71% since 2000, including an increase of over 46% in 2002.

The effect of California's strong tort reform regulations is clear when comparing rates between Los Angeles and Dade counties. Moreover, Dade County rates have been increasing continuously since 1995, while NY and Los Angeles rates have been stable during the same period.

[2] Annual Statement written premium includes both physician and hospital premium.

Question 3:

How are those increases broken down between economic damages, non-economic damages and defense costs?

Economic v. Non-Economic Losses
Based on the Florida DOI medical malpractice data, over 75% of the paid loss is non-economic loss (Exhibit 3a, Attachments 3 a-c). Note that only about a quarter of the records in the Archive database had payments broken out in these categories, while around 87% of the records in the Current database included this. Additionally, of cases showing this economic and non-economic split, only 55% of them sum to the actual total paid loss. We assume that economic and non-economic values are initial estimates of what will ultimately be paid and not necessarily components of the actual paid loss.

Similarly, only one third of the cases in the Texas DOI database have indemnity payments broken out into economic, non-economic, and "other" (exemplary/punitive damages and pre-judgment interest) categories. The cases with categorized indemnity payments tend to be the larger cases; severity for these cases is about 30% higher than the average severity. Unlike Florida, the indemnity components in the Texas DOI database sum to the total paid to plaintiffs in the Texas DOI database. Over $1 billion has been paid during the past 10 years for non-economic damages in Texas (Attachment 3c). In Texas, non-economic damages account for about 60% of the total paid loss while an additional 10% are in punitive and interest charges so that Florida and Texas both show that only 20%-30% of loss payments are for economic losses.

Loss v. Defense Costs
The Florida DOI database indicates that about 15% of total loss payments are for defense costs (Attachments 1a and 1d). However, this database does not include all of those cases in which defense costs were paid on cases without an indemnity loss payment. The 15% ratio thus understates the total paid out in defense costs. Based on other information from insurer rate filings and financial statements, we estimate that total defense costs exceed 20% of loss payments.

Additionally, defense costs do not appear to be a fixed percentage of total cost; defense costs tend to increase at a slower rate than loss payments. That is, it is relatively more expensive to defend a $50,000 case than a $5 million case. The relationship between losses and defense costs for Texas cases is shown as a log-log least squares regression[3] (Exhibit 3b). Though there is considerable variability in the relationship (r^2=0.243), a 10% increase in indemnity is accompanied by a 4.2% increase in LAE. Thus, if a $50,000 case costs $12,750 (25%) to defend, then a $500,000 is expected to cost about $41,230 (8%), and a $5 million case is expected to cost about $133,335 (3%) in defense costs.

[3] In this analysis, we eliminated 174 cases that had no LAE payment.

Question 4:

How are economic damages broken down between wages and medicals and how do those increases compare to the inflation index for wages and health care? Is there any way to tell if economic damages and defense costs are growing faster than non-economic damages?

Economic Damages: Wages and Medical Expenses

The Florida DOI database indicates that about three quarters of economic losses is related to medical expenses (Exhibit 4a; Attachment 3a,b). This percentage appears to be decreasing slowly, while the proportion of loss for wages are increasing.

Growth of economic losses, non-economic losses, and defense costs

Exhibit 4b presents a summary of results showing the growth of claim severity for losses and for defense costs. Also shown are indicated growth rates for the non-economic and economic damage portions of losses. Results are shown from several data sources, including:

Florida DOI data
NPDB data for Florida and nationwide
PIAA nationwide data
Texas data (from a Texas Insurance Department data base)

The growth rates are computed on a long-term (i.e. "historical") basis, using 10 or 11 years of data. They are also calculated on a more current basis, using the last 3 or 4 years.

The results generally show that the current growth rates are higher, indicating that the severities have increased in the most recent years. Results are somewhat spurious for some of the categories, particularly the current indications for hospitals, and for non-economic or economic damages, where the data is less extensive. Furthermore, the growth rates from the Florida physician DOI data are slightly less believable than the growth rates based upon the Florida NPDB data, because the DOI data was taken from two sources (the Archive and Current data bases described above) and the growth rate calculation is based on the assumption that the two data base sources are exactly comparable to each other. (The results are very close, but not exactly identical, between the two data sources.)

The results show high current severity growth rates for physician losses and defense costs in Florida and countrywide. The Florida NPDB data shows a current severity growth rate of approximately 10% for physicians.

The data underlying the growth rate calculations for non-economic and economic damages includes only those claims where non-economic and economic damages were separately identified. It appears that, in Florida, economic damages have historically increased at a greater rate than non-economic damages.

Question 5:

What are the historical trends on frequency of claims? What would they be when population growth is factored in?

Based on Florida population information from the Census Bureau, we have analyzed the relationship of claims to population over time. The Florida DOI database indicates that the number of claims per physician increased from 1990 through 1997. This is shown graphically in Exhibit 5a and numerically in Attachment 5. As we understand the Current database may only be capturing a subset of the claims in the Archive database, we do not feel that the data would be appropriate to gauge a frequency trend for the most recent years after 1997.

Exhibit 5b shows a graphical comparison between Florida and countrywide claim frequency using data reported to the NPDB (see also the table immediately below). These data show a strong upward trend in the number (and frequency) of Florida claims and a corresponding stationary pattern for countrywide claims. Between 1991 and 1995 the population-adjusted frequency for Florida was approximately equal to the countrywide average but, unlike the relatively stationary countrywide trend, the Florida rate has been increasing. By 2000, Florida's rate (7.56 NPDB reported claims per 100,000 per year) was 36% higher than the countrywide average and 57% higher than it had been a decade earlier. During the same period, the countrywide average remained unchanged.

	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Population x 100,000										
USA	2,530	2,565	2,599	2,631	2,663	2,694	2,726	2,759	2,790	2,814
Florida	134	137	139	142	145	149	152	155	158	160
Cases										
USA	13,711	14,739	14,667	15,171	14,050	15,275	14,609	14,086	15,117	15,602
Florida	644	719	786	811	849	1,076	1,100	1,025	1,045	1,209
Frequency (Cases / Population x 100,000)										
USA	5.42	5.75	5.64	5.77	5.28	5.67	5.36	5.11	5.42	5.54
Florida	4.82	5.27	5.64	5.70	5.84	7.24	7.24	6.62	6.63	7.56

Question 6:

What kinds of comparisons can be made between South Florida and North Florida in terms of claims data, premiums, frequency, etc.?

Based on the Florida DOI database, we have analyzed the data in three separate groups. Territory 1 includes Dade and Broward counties; Territory 2 includes Palm Beach, Hillsborough, Pinellas, Orange and Duval counties; and, Territory 3 includes the remaining counties in Florida. Overall, since 1985, claims counts have been split *approximately* evenly between the three territories (Attachment 6a), with Territory 1 accounting for 35%-37% of claims, Territory 2 for 33%, and Territory 3 for 30%-32%. However, there appears to be a shift in frequency underway (Exhibit 6a). The percentage of cases in Territory 3 is growing and the percentage of cases in Territory 1 is shrinking (with Territory 2 remaining stationary at about one-third of claims). During the mid-1980's, Territory 3 accounted for about 28% of physician claims; in the most recent years, about 40% of claims occur in Territory 3.

Similarly, over the last 18 years, Territory 1 has accounted for 35%-39% of paid losses; Territory 2, 33%-34%; and Territory 3, 27%-32% (Attachment 6b). The paid loss pattern follows the claim count pattern; Territory 3 is growing, while relative losses in Territory 1 have been decreasing (Exhibit 6b).

There appears to be little difference in the size of claims between territories (Exhibit 6c,e; Attachments 6c-e). Although there is great variability in relative average claim size from year-to-year (and much more variability in hospital claims than physician claims), all three territories show *approximately* the same average cases size (Territory 3 *might* have a slightly lower relative severity than the other two territories). There is no clear trend in relativity between territories.

Relative expense size does not appear to have varied over time, though it does appear that defense costs in Territory 1 are highest, followed by Territory 2, and finally Territory 3 (Exhibits 6 d, e; Attachments 6 f-h).

Population adjusted relative claim frequency (Exhibit 6f; Attachments 6i-k) is much lower in Territory 3 than the other two territories. However, relative claim frequency is slowly growing in Territory 3 (from about 0.60 to 0.85 times the statewide average) and falling in Territory 1 (from over 1.50 times the statewide average down to near unity). Additionally, census bureau data indicate that the population of Territory 3 is growing at a faster rate than the other two territories (2.3% v. 1.9%) and Territory 3 now makes up for about 47% of Florida's population (up from 45% in 1985). These factors (population growth in Territory 3, increase in relative per capita claim rate in Territory 3, decrease in relative per capita claim rate in Territory 1) account for the shift in total claims and paid losses from Territory 1 to Territory 3.

Question 7:

How much of the premium dollar goes to plaintiff's attorney's, defense attorneys, defense costs, claimant, underwriting costs/profit?

Plaintiff's attorney's fees are a portion of losses, which are paid by the successful plaintiffs to their attorneys. We have no data from any of our sources to accurately quantify the percentage of losses which are paid in attorneys fees. However, we believe that attorneys fees equal approximately 30% of losses.

The portion of the premium dollar to cover various loss and expense amounts varies by insurer and by state. However, much information is available from insurer Annual Statements about many of these expense components. Based on this information, plus our experience and judgment, we estimate the following percentages.

Plaintiffs (exclusive of plaintiff's attorneys fees)	49%
Plaintiff's attorneys fees	21%
Defense attorneys fees	17%
Other defense expenses	3%
Insurer administrative expenses and profit	10%
Total	100%

Question 8:

What are the average payouts per state?

Exhibit 7 shows NPDB losses for the 10 largest medical malpractice states. These states account for about two-thirds of medical malpractice losses in the United States (Attachment 7a-e).

Perhaps the most dramatic finding within the NPDB is the extremely low loss rate for physicians in California. Presumably, California's per physician loss rate of just below 50% of the countrywide average is due to the well-known and long established tort reforms in place (California's Medical Injury Compensation Reform Act of 1975 "MICRA"). As previously discussed, the lower losses result in significantly lower premiums for California physicians (Exhibit 2c). MICRA apparently impacts both frequency and severity of malpractice cases. The 2000 claim frequency for California physicians equals about 75% of the U.S. average. Additionally, the 2000 average claim severity in California is less than 60% of the U.S. average and the 2000 loss per physician (pure premium) equals about 42% of the U.S. average.

In Florida, the rate at which physician claims get reported to the NPDB (frequency) is more than 25% higher than the countrywide average over the 10-year period ending 4/30/2001. Coupled with a 6% higher cost per case (severity) leaves Florida physicians with a total exposure 36% higher than the countrywide average over the 10-year period (and more than 250% greater than California!).

For cases reported in 2000, the Florida statistics show more deterioration. Claim frequency increases to 50% above the U.S. average and pure premium increases to 55% above the U.S. average. The 2000 Florida claim frequency is exceeded only by the claim frequency in Nevada, West Virginia, Pennsylvania, and Montana. The 2000 Florida pure premium is exceeded only by the pure premiums in Nevada, West Virginia, Pennsylvania, D.C., New York, and Montana (Attachment 7e).

Question 9:

Can you determine what % of claims arises out of the emergency room including any subsequent surgery?

The Florida DOI database contains a field for "Event Location" that includes the following categories:

Hospital Inpatient
Emergency Room (E/R)
Physician's Home/Office
Hospital Outpatient
Nursing Home
Patient's Home
Other Outpatient (presumably free standing clinics, for example)
Other (Non-Specified) Location
Other Hospital/Institution

During the 17-year period (1986-2001) for which these data have been collected, nearly 90% of all events occurred in the Hospital Inpatient, E/R, and Physician's Office categories (with each of the remaining categories accounting for less than about 5%). Emergency Room cases make up about 10% of claim counts and dollars (Exhibit 8a; Attachment8)[4].

Over time, there has been considerable variability in the proportion of E/R cases, but there is no indication of a change in the relative size of this category (Exhibit 8b). However, the relative proportion of Hospital Inpatient cases has been decreasing (from about 70% to about 50%) while the relative size of the Outpatient categories ("hospital" and "other" combined) has grown and now appears to make up about 10% of total losses. No other single category appears to show a change in frequency.

[4] Note that while the 10% pertains to claims, which originated directly from the E/R, there may be additional related claims, which apply to treatment in other areas, (e.g. surgery) after leaving the E/R. Thus the true percentage of claims attributable to E/R treatment may be understated.

LIMITATIONS

Data

In performing this analysis we have relied on data and other information obtained from publicly available sources. We have not audited, verified, or reviewed this data and other information for reasonableness and consistency. Such a review is beyond the scope of our assignment. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

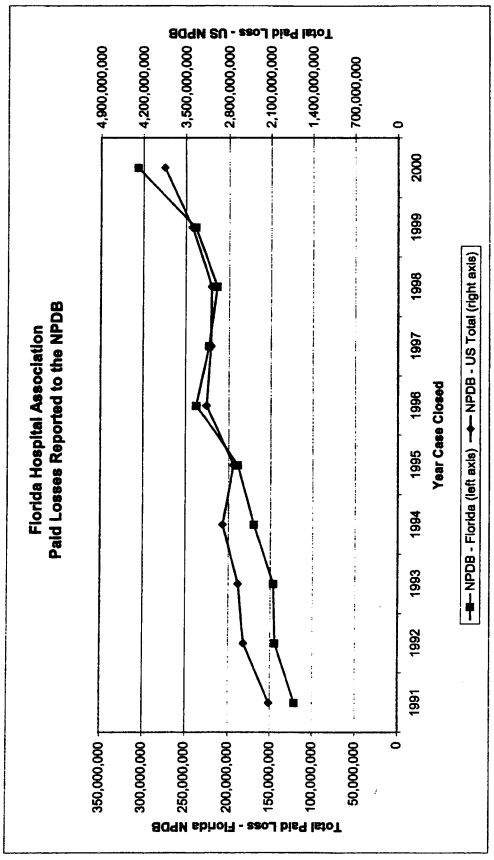
Variability of Results

Any estimate of future claim activity, particularly with respect to the potential impact of various tort reform measures, is necessarily subject to a substantial amount of uncertainty. Tort reform measures that may account for apparent reductions in one state may not have a similar effect in other states. The actual loss experience that develops subsequent to enacted tort reform measures may turn out to be substantially different than expected.

Distribution

Our analysis has been done at the request of the Florida Hospital Association and they are the only party that can rely on our report. The FHA has expressed its intention to distribute this report and, in particular, to distribute the Observations / Conclusions section of the report to other interested third parties. Milliman agrees to such distribution with the understanding that Milliman does not intend to benefit any third party recipient of its work product or create any legal duty from Milliman to a third party. As such no third party receiving this report may rely on the work or conclusions contained herein. We recommend that any recipient have it's own actuary or economist review the work and form an independent opinion. We also require that any press release that refers to the report be submitted to Milliman for prior approval.

Exhibit 1a



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m:\025FHA\Exhibits_FHA.xls Exhibit 1a

Exhibit 1d

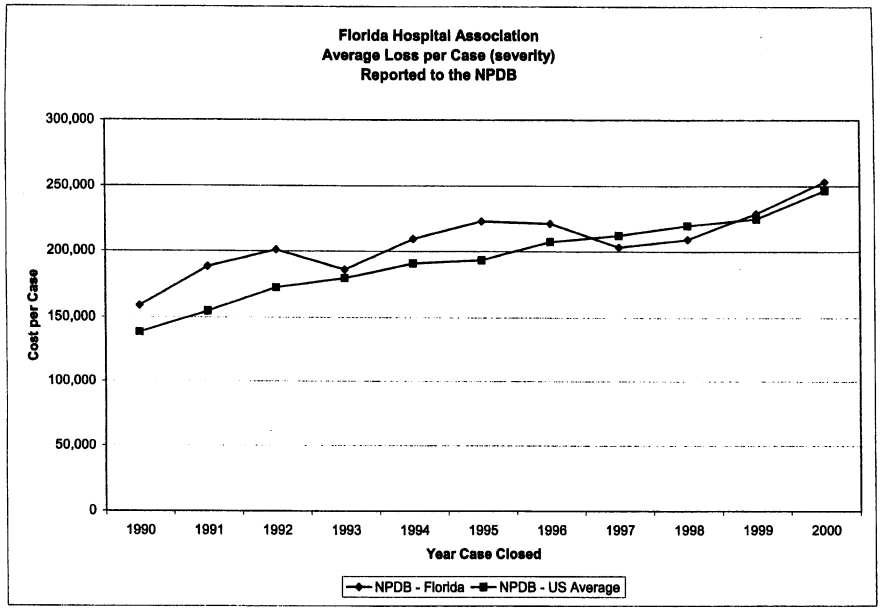


Exhibit 1b

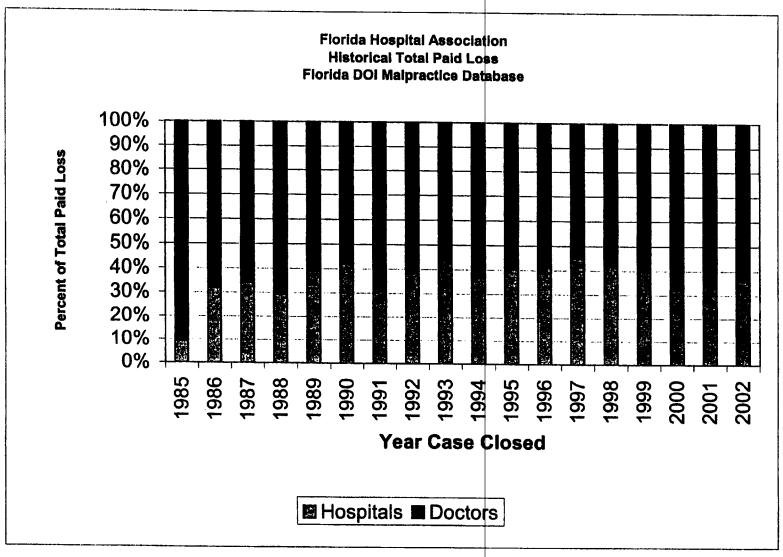


Exhibit 1e

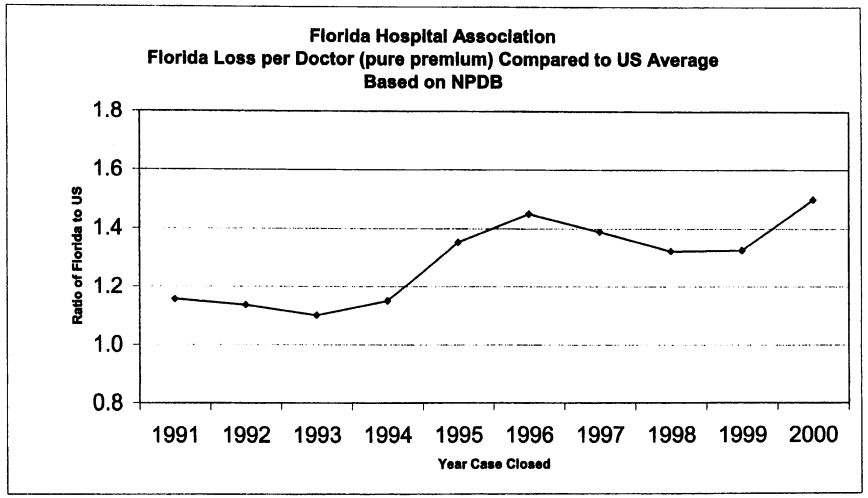


Exhibit 1c

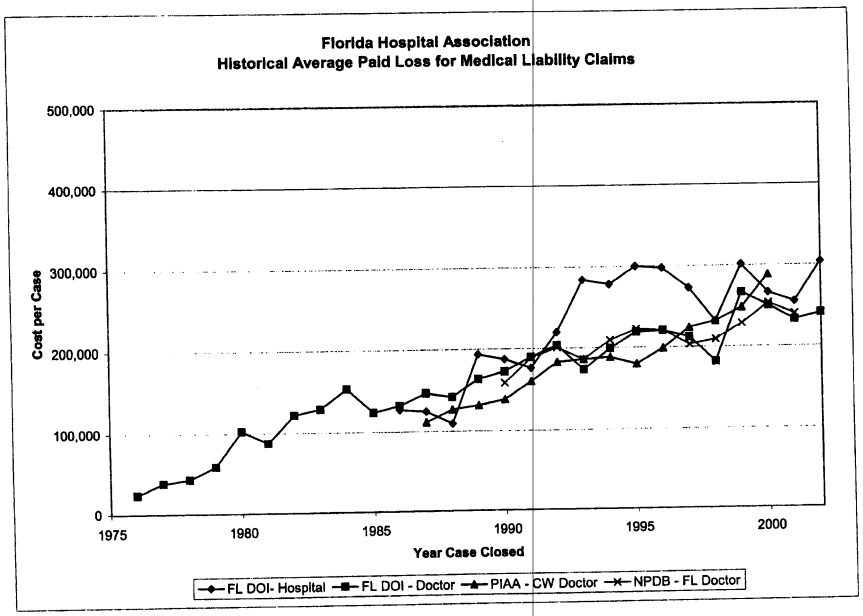


Exhibit 2b

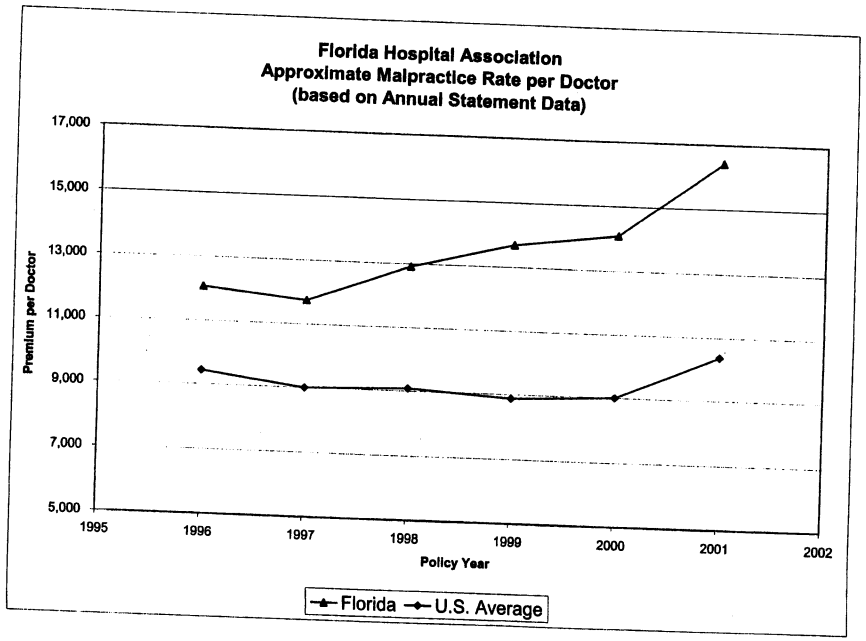
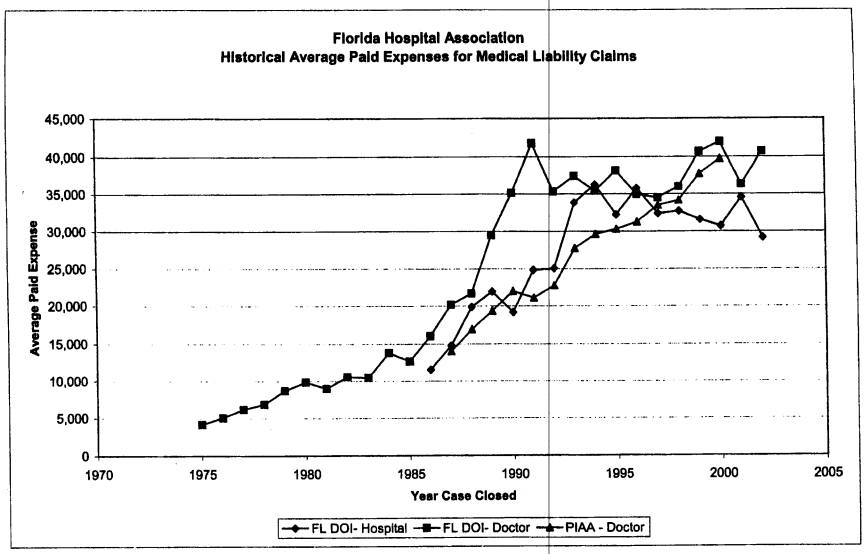


Exhibit 1f



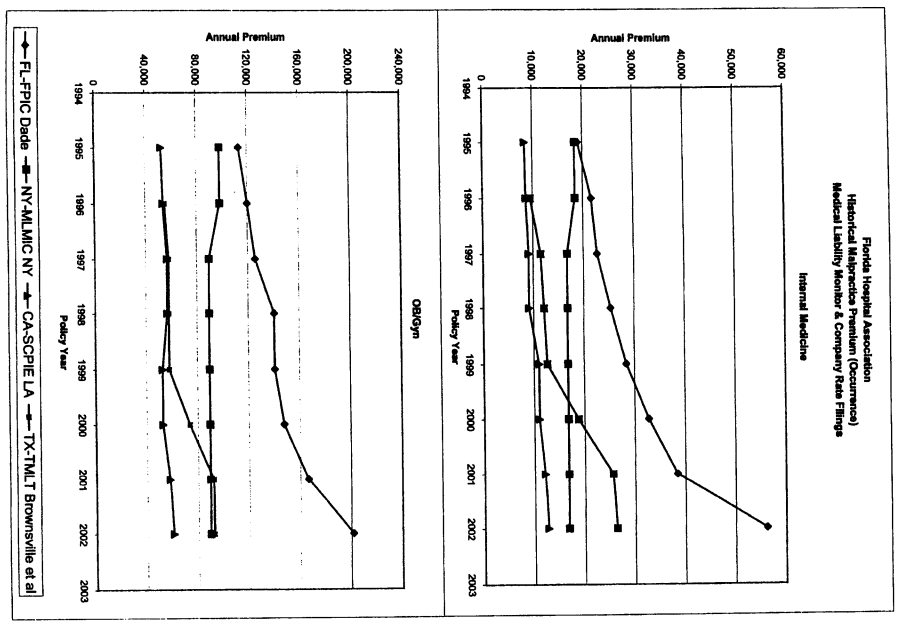


Exhibit 2a

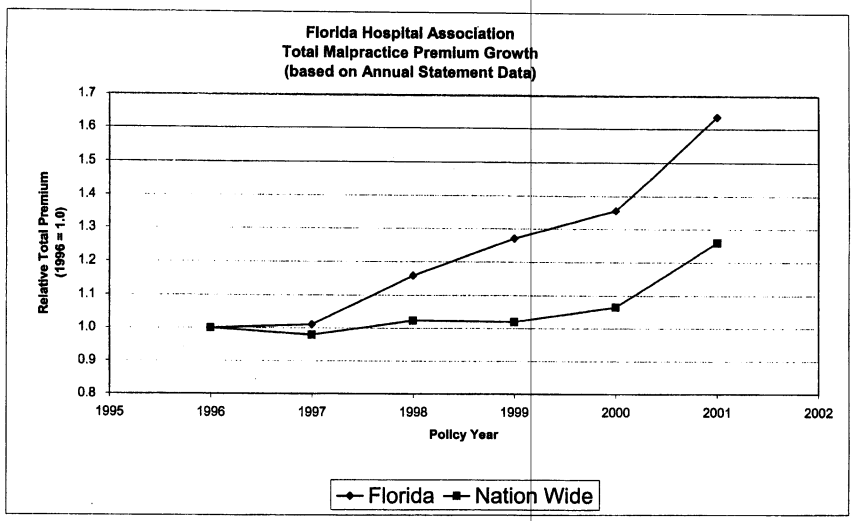


Exhibit 3a

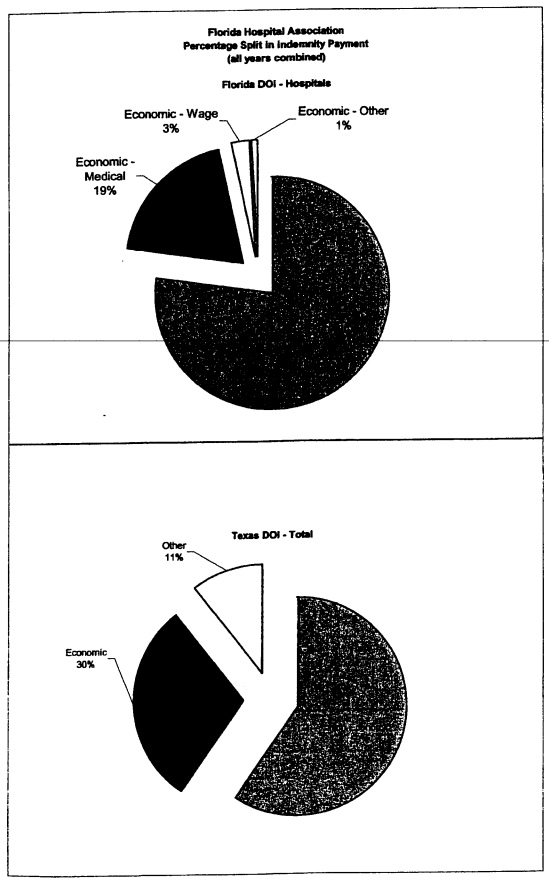


Exhibit 3b

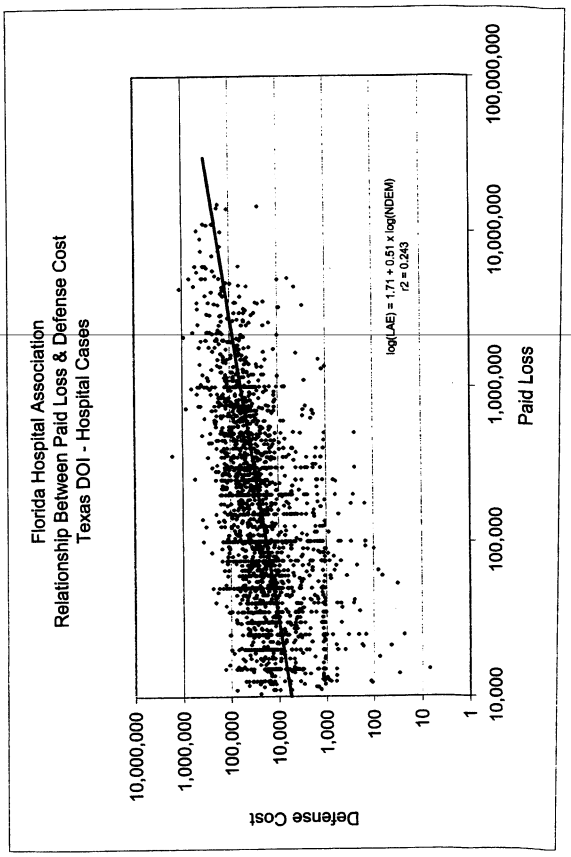


Exhibit 4a

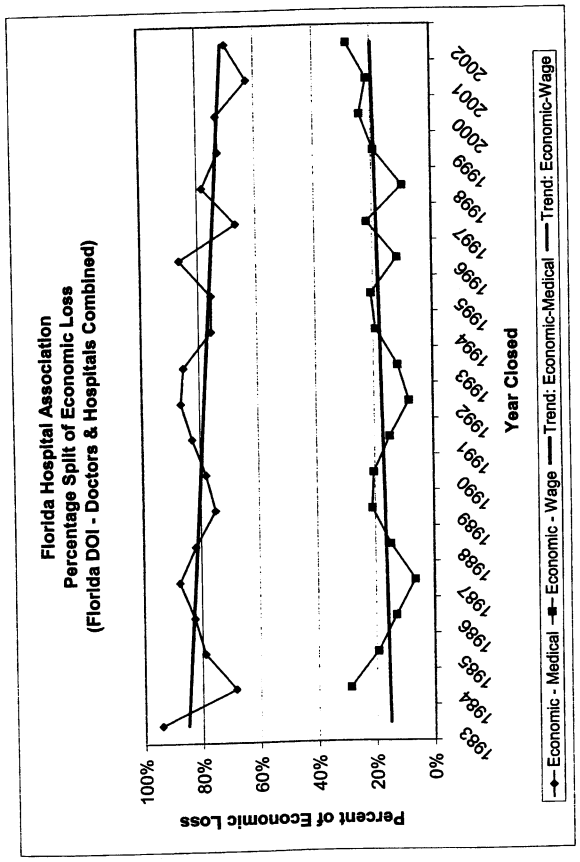


Exhibit 4b

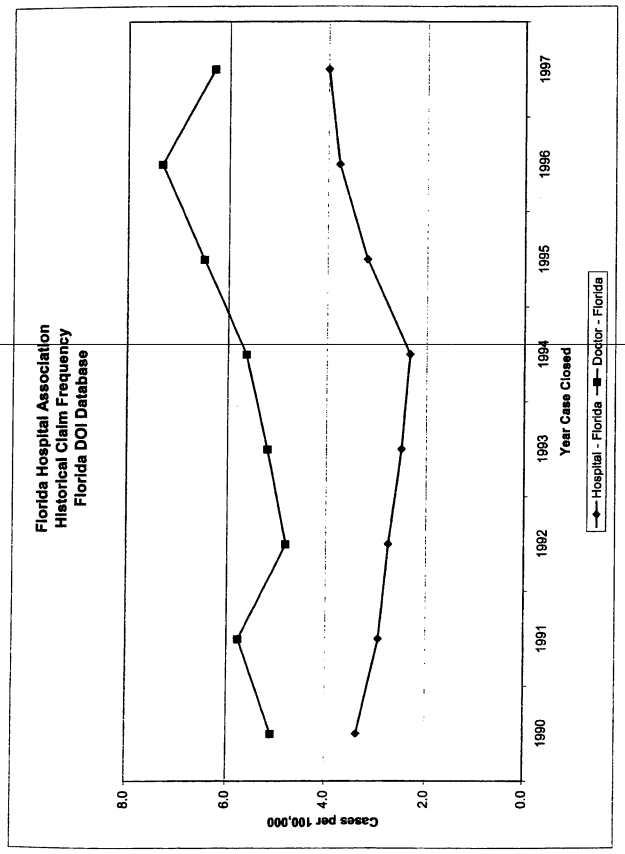
Florida Hospital Association
Estimated Severity Trend (Annual Growth) Rates

	Historical Indication	Current Indication	Attachment Reference
Total Loss			
Florida DOI - Hospitals	2.1%	1.6%	1a
Florida DOI - Doctors	2.7%	7.0%	1a
Nationwide PIAA - Doctors	5.7%	11.5%	1b
Nationwide NPDB - Doctors	4.6%	6.0%	1c
Florida NPDB - Doctors	2.5%	10.1%	1c
Texas - Doctors & Hospitals	3.7%	11.1%	4d
Non-Economic Damages			
Florida DOI - Hospitals	6.8%	-2.4%	4a
Florida DOI - Doctors	2.6%	4.3%	4a
Texas - Doctors & Hospitals	8.5%	20.6%	4c
Economic Damages			
Florida DOI - Hospitals	2.5%	2.4%	4b
Florida DOI - Doctors	11.2%	3.0%	4b
Texas - Doctors & Hospitals	4.6%	34.2%	4c
Total Expenses			
Florida DOI - Hospitals	1.9%	-3.1%	1d
Florida DOI - Doctors	0.4%	7.9%	1d
Nationwide PIAA - Doctors	6.7%	7.9%	1e
Texas - Doctors & Hospitals	6.4%	9.7%	4d

Notes:
"Historical" trend encompasses:
1991-2001 for Florida DOI data.
1991-2000 for other data sources.

"Current" trend encompasses:
1998-2001 for Florida DOI data.
1998-2000 for other data sources.

Exhibit 5a



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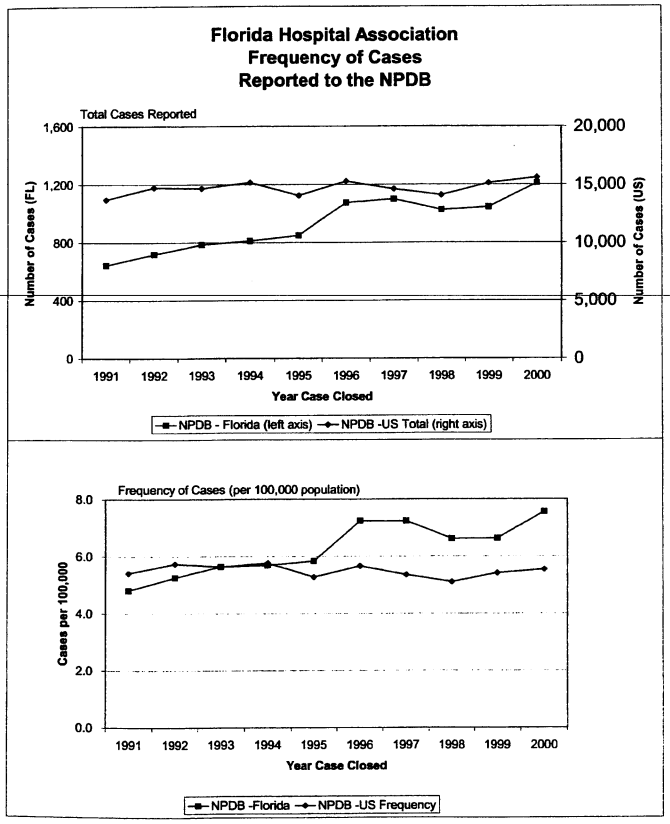
m:\023FHAE\exhibits_FHA.xls Exhibit 5a

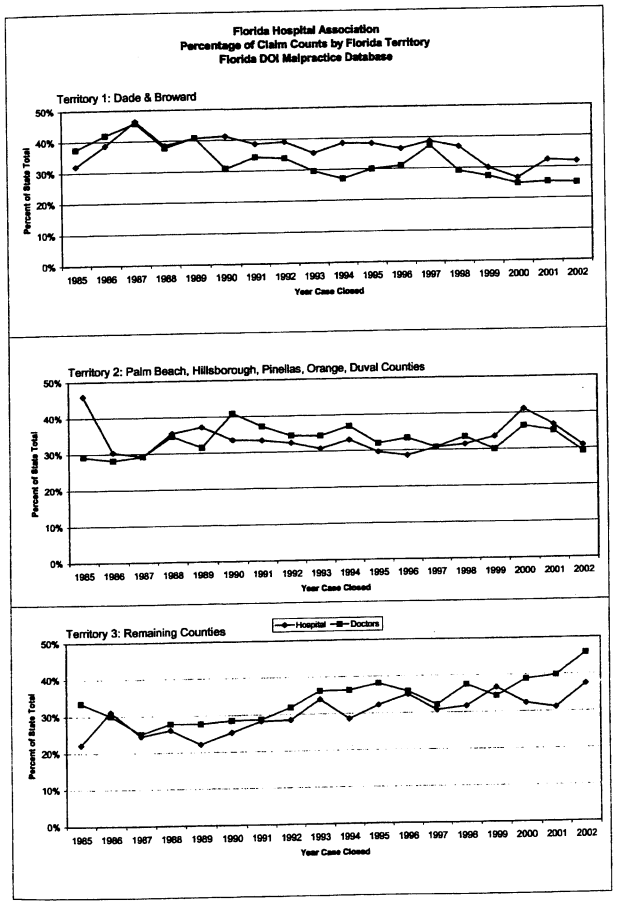
Exhibit 5b



m:\023FHAE\exhibits_FHA.xls Exhibit 5b

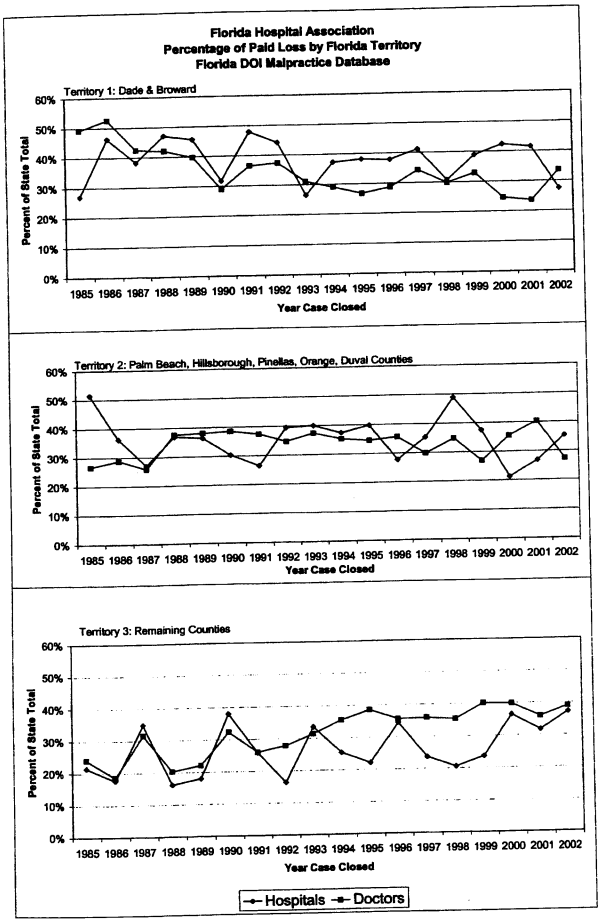
MILLIMAN USA

Exhibit 6a



MILLIMAN USA

Exhibit 6b



MILLIMAN USA

Exhibit 6c

Florida Hospital Association
Relative Claim Size (severity) by Florida Territory
Florida DOI Malpractice Data

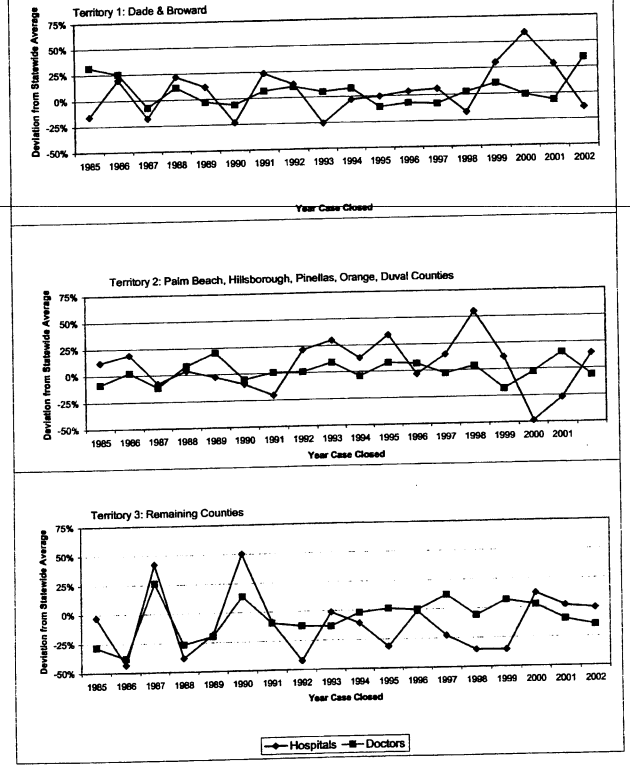


Exhibit 6d

Florida Hospital Association
Relative Expense (severity) by Florida Territory
Florida DOI Malpractice Database

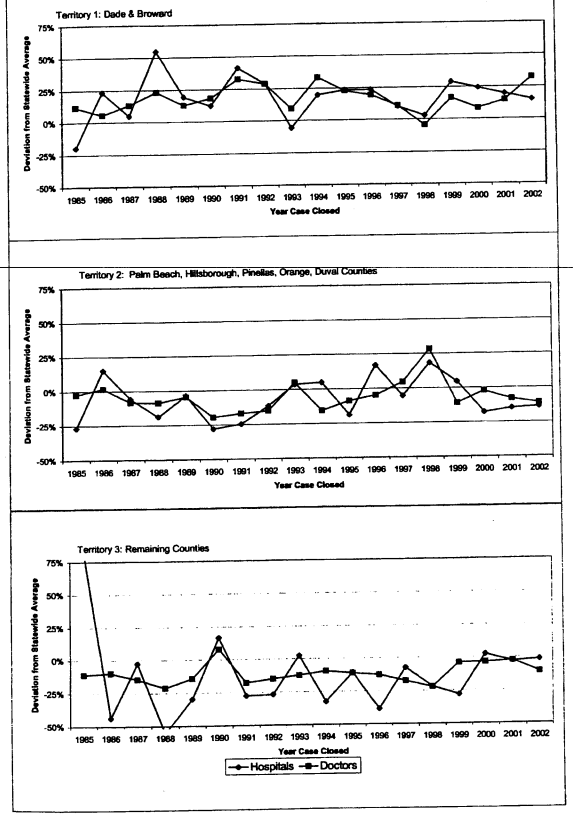


Exhibit 6e

Florida Hospital Association
Relative Severity by Florida Territory
Florida DOI - Doctor Losses

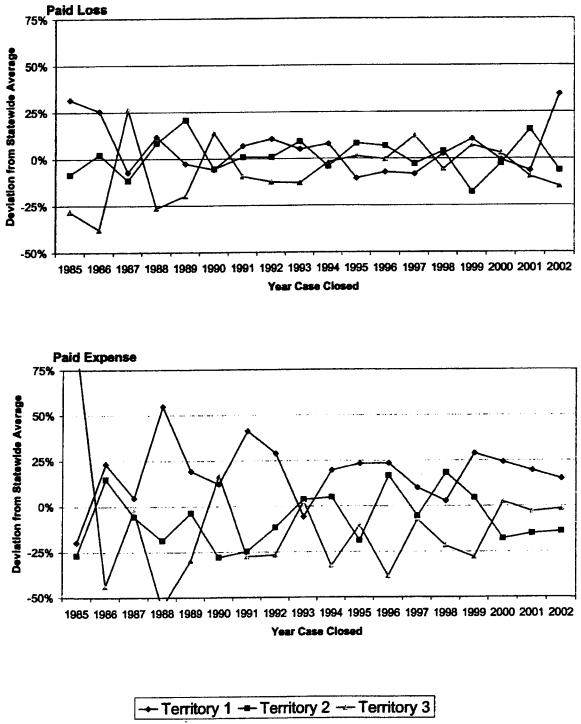


Exhibit 6f

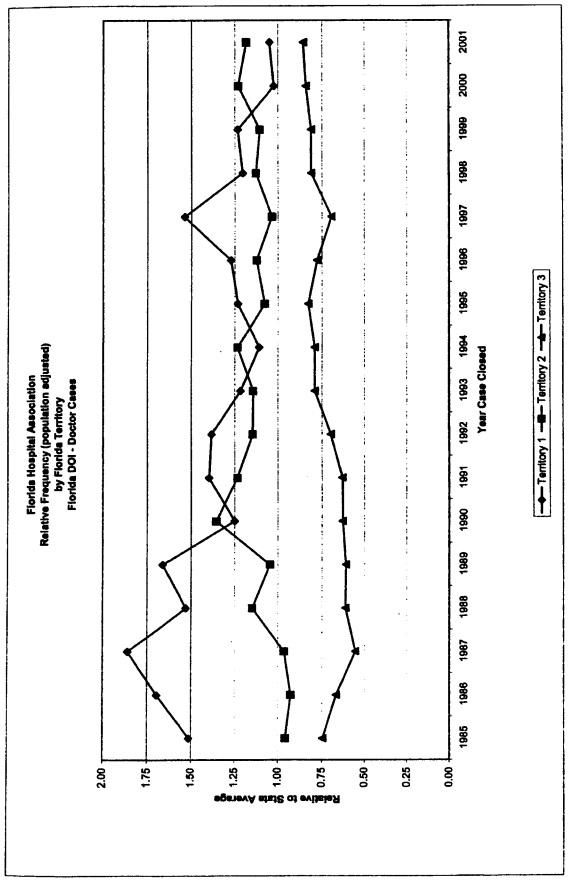
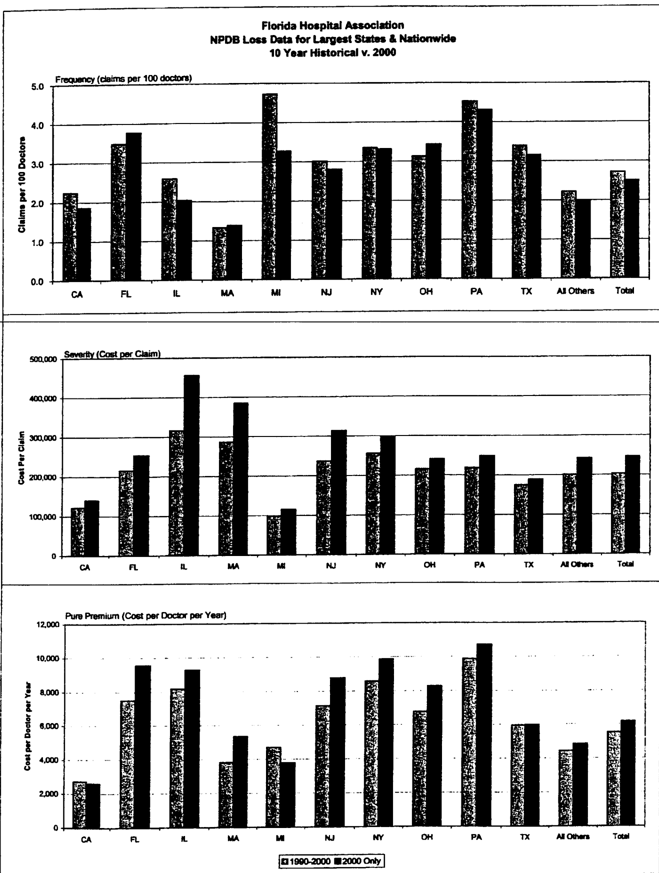
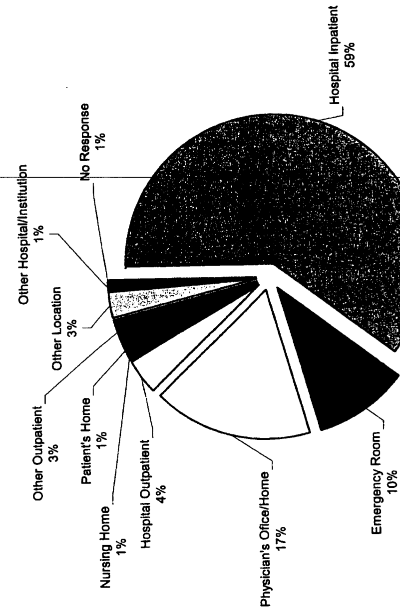


Exhibit 7



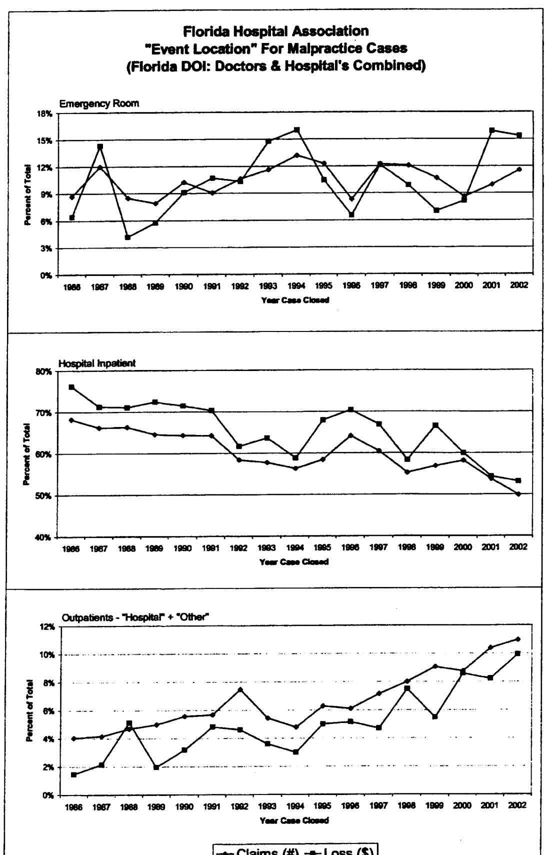
MILLIMAN USA

Exhibit 8a



MILLIMAN USA

Exhibit 8b



MILLIMAN USA

Attachment 1a

Florida Hospital Association
Historical Average Annual Increase in Paid Loss for Medical Liability Claims
Total Florida
(Based on data from the Florida Database)

	(1)	(2)	(3) (1) / (2)	(4) (3) / Prior (3)	(5)	(6)	(7) (5) / (6)	(8) (7) / Prior (7)
	Hospital				Physician			
Claim Close Year	Total Paid Loss	Closed with Indemnity Payment Claims	Average Paid Loss	% of Annual Increase in Average Paid Loss	Total Paid Loss	Closed with Indemnity Payment Claims	Average Paid Loss	% of Annual Increase in Average Paid Loss
(Blank)	-	-	0		-	-	0	
1973	-	-	0	0%	132,050	4	33,013	0%
1974	-	-	0	0%	173,606	15	11,574	-65%
1975	450	-	0	0%	10,928,410	375	29,142	152%
1976	-	1	0	0%	8,228,905	347	23,714	-19%
1977	-	-	0	0%	12,024,676	322	37,344	57%
1978	2,500	1	2,500	0%	12,073,695	288	41,923	12%
1979	-	-	0	-100%	13,951,157	240	58,130	39%
1980	-	-	0	0%	28,030,435	273	102,676	77%
1981	-	-	0	0%	38,222,579	438	87,266	-15%
1982	-	-	0	0%	69,497,477	569	122,140	40%
1983	1,000	1	1,000	0%	76,051,873	590	128,901	6%
1984	157,750	5	31,550	3055%	97,112,320	634	153,174	19%
1985	9,171,482	122	75,176	138%	90,581,104	731	123,914	-19%
1986	51,013,695	402	126,900	69%	109,751,258	832	131,913	6%
1987	66,170,125	531	124,614	-2%	127,160,779	866	146,837	11%
1988	47,815,338	437	109,417	-12%	115,275,908	811	142,140	-3%
1989	82,384,222	425	193,845	77%	128,430,232	784	163,814	15%
1990	82,368,753	439	187,628	-3%	114,633,621	664	172,641	5%
1991	69,586,661	394	176,616	-6%	146,534,933	771	190,058	10%
1992	82,578,410	376	219,623	24%	133,781,196	657	203,624	7%
1993	98,806,335	348	283,926	29%	125,845,187	724	173,819	-15%
1994	92,665,232	333	278,274	-2%	159,777,554	802	199,224	15%
1995	139,879,171	466	300,170	8%	206,449,199	942	219,161	10%
1996	166,817,962	560	297,889	-1%	239,875,827	1,087	220,677	1%
1997	165,565,239	607	272,760	-8%	202,750,624	955	212,304	-4%
1998	129,660,115	559	231,950	-15%	182,241,758	1,001	182,060	-14%
1999	144,049,259	478	301,358	30%	220,966,498	828	266,868	47%
2000	116,189,593	436	266,490	-12%	223,149,549	891	250,448	-6%
2001	106,649,114	418	255,141	-4%	205,677,297	882	233,194	-7%
2002	32,537,113	107	304,085	19%	57,912,565	240	241,302	3%
Trend								Severity
All Yr	1,684,069,519	7,446	226,171		3,157,222,272	18,563	170,081	
91-01	1,312,447,091	4,975	263,808	2.1%	2,047,049,622	9,540	214,575	2.7%
98-01	496,548,081	1,891	262,585	1.6%	832,035,102	3,602	230,993	7.0%

Florida Hospital Association Attachment 1d

Historical Average Annual Increase in Paid Expense for Medical Liability Claims

Total Florida

(Based on data from the Florida Database)

	(1)	(2)	(3) (1) / (2)	(4) (3) / Prior (3)	(5)	(6)	(7) (5) / (6)	(8) (7) / Prior (7)
	Hospital				Physician			
Claim Close Year	Total Paid Expense	Closed with Indemnity Payment Claims	Average Paid Expense	% of Annual Increase in Average Paid Expense	Total Paid Expense	Closed with Indemnity Payment Claims	Average Paid Expense	% of Annual Increase in Average Paid Expense
(Blank)	-	-	0		-	-	0	
1973	-	-	0	0%	17,613	4	4,403	0%
1974	-	-	0	0%	25,479	15	1,699	-61%
1975	-	-	0	0%	1,562,442	375	4,167	145%
1976	-	1	0	0%	1,762,875	347	5,080	22%
1977	-	-	0	0%	1,996,599	322	6,201	22%
1978	375	1	375	0%	1,985,132	288	6,893	11%
1979	-	-	0	-100%	2,090,730	240	8,711	26%
1980	-	-	0	0%	2,693,662	273	9,867	13%
1981	-	-	0	0%	3,944,491	438	9,006	-9%
1982	-	-	0	0%	6,016,530	569	10,574	17%
1983	-	1	0	0%	6,178,310	590	10,472	-1%
1984	27,588	5	5,518	0%	8,748,236	634	13,798	32%
1985	1,109,492	122	9,094	65%	9,243,012	731	12,644	-8%
1986	4,636,841	402	11,534	27%	13,353,637	832	16,050	27%
1987	7,853,532	531	14,790	28%	17,456,603	866	20,158	26%
1988	8,677,827	437	19,858	34%	17,596,100	811	21,697	8%
1989	9,311,649	425	21,910	10%	23,103,765	784	29,469	36%
1990	8,409,431	439	19,156	-13%	23,338,334	664	35,148	19%
1991	9,788,262	394	24,843	30%	32,202,040	771	41,767	19%
1992	9,418,082	376	25,048	1%	23,208,154	657	35,324	-15%
1993	11,770,074	348	33,822	35%	27,103,148	724	37,435	6%
1994	12,079,269	333	36,274	7%	28,383,605	802	35,391	-5%
1995	15,010,094	466	32,211	-11%	35,953,296	942	38,167	8%
1996	20,037,621	560	35,781	11%	37,984,642	1,087	34,944	-8%
1997	19,642,117	607	32,359	-10%	32,933,006	955	34,485	-1%
1998	18,285,505	559	32,711	1%	36,033,361	1,001	35,997	4%
1999	15,087,561	478	31,564	-4%	33,695,269	828	40,695	13%
2000	13,390,210	436	30,711	-3%	37,362,455	891	41,933	3%
2001	14,439,763	418	34,545	12%	32,039,001	882	36,325	-13%
2002	3,121,417	107	29,172	-16%	9,770,570	240	40,711	12%
Trend								Severity
All Yr	184,535,530	6,921	26,663		465,972,526	17,441	26,717	
91-00	133,752,104	4,507	29,677	1.9%	300,243,351	8,387	35,799	0.4%
98-00	57,965,243	1,726	33,584	-3.1%	106,951,009	3,043	35,147	7.9%

Florida Hospital Association Attachment 1b

Historical Average Annual Increase in Paid Loss for Medical Liability Claims

Countrywide

(Based on PIAA Claim Trend Analysis 2000 Edition)

	(1)	(2)	(3) (1) / (2)	(4) (3) / Prior (3)	(5)	(6)	(7) (5) / (6)	(8) (7) / Prior (7)
	Hospital				Physician			
Claim Close Year	Total Paid Loss	Closed with Indemnity Payment Claims	Average Paid Loss	% of Annual Increase in Average Paid Loss	Total Paid Loss	Closed with Indemnity Payment Claims	Average Paid Loss	% of Annual Increase in Average Paid Loss
(Blank)	-	-	-		-	-	-	
1973	-	-	-	-	-	-	-	-
1974	-	-	-	-	-	-	-	-
1975	-	-	-	-	-	-	-	-
1976	-	-	-	-	-	-	-	-
1977	-	-	-	-	-	-	-	-
1978	-	-	-	-	-	-	-	-
1979	-	-	-	-	-	-	-	-
1980	-	-	-	-	-	-	-	-
1981	-	-	-	-	-	-	-	-
1982	-	-	-	-	-	-	-	-
1983	-	-	-	-	-	-	-	-
1984	-	-	-	-	-	-	-	-
1985	-	-	-	-	-	-	-	-
1986	-	-	-	-	-	-	-	-
1987	-	-	-	-	444,408,203	3,991	111,353	-
1988	-	-	-	-	487,393,082	3,845	126,760	14%
1989	-	-	-	-	437,304,382	3,325	131,520	4%
1990	-	-	-	-	434,287,377	3,138	138,396	5%
1991	-	-	-	-	489,947,025	3,057	160,271	16%
1992	-	-	-	-	675,717,634	3,687	183,270	14%
1993	-	-	-	-	708,302,001	3,797	186,543	2%
1994	-	-	-	-	660,624,850	3,502	188,642	1%
1995	-	-	-	-	598,845,849	3,327	179,996	-5%
1996	-	-	-	-	625,576,445	3,144	198,975	11%
1997	-	-	-	-	672,450,640	3,002	224,001	13%
1998	-	-	-	-	636,756,515	2,744	232,054	4%
1999	-	-	-	-	607,695,576	2,446	248,445	7%
2000	-	-	-	-	481,446,370	1,668	288,637	16%
2001	-	-	-	-	-	-	-	-
2002	-	-	-	-	-	-	-	-
Trend					Paid Loss			Severity
All Yr					7,960,755,949	44,673	178,201	
91-00				-	6,157,362,905	30,374	202,718	5.7%
98-00				-	1,725,898,461	6,858	251,662	11.5%

Florida Hospital Association Attachment 1e

Historical Average Annual Increase in Total Paid Expense for Medical Liability Claims

Countrywide

(Based on PIAA Claim Trend Analysis 2000 Edition)

	(1)	(2)	(3) (1) / (2)	(4) (3) / Prior (3)	(5)	(6)	(7) (5) / (6)	(8) (7) / Prior (7)
	Hospital				Physician			
Claim Close Year	Total Paid Expense	Closed with Indemnity Payment Claims	Average Paid Expense	% of Annual Increase in Average Paid Expense	Total Paid Expense	Closed with Indemnity Payment Claims	Average Paid Expense	% of Annual Increase in Average Paid Expense
(Blank)	-	-	-		-	-	-	-
1973	-	-	-	-	-	-	-	-
1974	-	-	-	-	-	-	-	-
1975	-	-	-	-	-	-	-	-
1976	-	-	-	-	-	-	-	-
1977	-	-	-	-	-	-	-	-
1978	-	-	-	-	-	-	-	-
1979	-	-	-	-	-	-	-	-
1980	-	-	-	-	-	-	-	-
1981	-	-	-	-	-	-	-	-
1982	-	-	-	-	-	-	-	-
1983	-	-	-	-	-	-	-	-
1984	-	-	-	-	-	-	-	-
1985	-	-	-	-	-	-	-	-
1986	-	-	-	-	-	-	-	-
1987	-	-	-	-	55,917,402	3,991	14,011	-
1988	-	-	-	-	65,031,505	3,845	16,913	21%
1989	-	-	-	-	64,363,140	3,325	19,357	14%
1990	-	-	-	-	69,007,729	3,138	21,991	14%
1991	-	-	-	-	64,444,039	3,057	21,081	-4%
1992	-	-	-	-	83,988,140	3,687	22,780	8%
1993	-	-	-	-	105,367,253	3,797	27,750	22%
1994	-	-	-	-	103,727,511	3,502	29,620	7%
1995	-	-	-	-	100,818,797	3,327	30,303	2%
1996	-	-	-	-	98,244,794	3,144	31,248	3%
1997	-	-	-	-	100,476,934	3,002	33,470	7%
1998	-	-	-	-	93,725,935	2,744	34,157	2%
1999	-	-	-	-	92,310,081	2,446	37,739	10%
2000	-	-	-	-	66,317,430	1,668	39,759	5%
2001	-	-	-	-	-	-	-	-
2002	-	-	-	-	-	-	-	-
Trend					Paid Expense			Severity
All Yr	-	-	-	-	1,163,740,690	44,673	26,050	
91-00	-	-	-	-	912,111,213	31,844	28,643	6.7%
98-00	-	-	-	-	286,512,950	8,192	34,975	7.9%

Florida Hospital Association Attachment 1c

Historical Average Annual Increase in Paid Loss for Medical Liability Claims

Countrywide

(Based on NPDB Public Use Data File - 4/30/01)

	(1)	(2)	(3) (1) / (2)	(4) (3) / Prior (3)	(5)	(6)	(7) (5) / (6)	(8) (7) / Prior (7)
	Florida				Countrywide			
Claim Close Year	Total Paid Loss	Closed with Indemnity Payment Claims	Average Paid Loss	% of Annual Increase in Average Paid Loss	Total Paid Loss	Closed with Indemnity Payment Claims	Average Paid Loss	% of Annual Increase in Average Paid Loss
(Blank)	-	-	-		-	-	-	
1973	-	-	-	-	-	-	-	-
1974	-	-	-	-	-	-	-	-
1975	-	-	-	-	-	-	-	-
1976	-	-	-	-	-	-	-	-
1977	-	-	-	-	-	-	-	-
1978	-	-	-	-	-	-	-	-
1979	-	-	-	-	-	-	-	-
1980	-	-	-	-	-	-	-	-
1981	-	-	-	-	-	-	-	-
1982	-	-	-	-	-	-	-	-
1983	-	-	-	-	-	-	-	-
1984	-	-	-	-	-	-	-	-
1985	-	-	-	-	-	-	-	-
1986	-	-	-	-	-	-	-	-
1987	-	-	-	-	-	-	-	-
1988	-	-	-	-	-	-	-	0%
1989	-	-	-	-	-	-	-	0%
1990	20,304,050	128	158,625	0%	298,314,050	2,147	138,945	0%
1991	121,368,350	644	188,460	19%	2,119,871,750	13,711	154,611	11%
1992	144,527,850	719	201,012	7%	2,544,346,350	14,739	172,627	12%
1993	146,440,000	786	186,310	-7%	2,638,740,200	14,667	179,910	4%
1994	169,668,850	811	209,209	12%	2,897,405,700	15,171	190,983	6%
1995	188,983,050	849	222,595	6%	2,719,077,050	14,050	193,529	1%
1996	237,694,550	1,076	220,906	-1%	3,165,529,100	15,275	207,236	7%
1997	223,530,000	1,100	203,209	-8%	3,096,304,100	14,609	211,945	2%
1998	214,219,300	1,025	208,994	3%	3,090,143,150	14,086	219,377	4%
1999	238,864,100	1,045	228,578	9%	3,395,572,250	15,117	224,619	2%
2000	306,424,550	1,209	253,453	11%	3,847,696,900	15,602	246,616	10%
2001	102,483,600	427	240,008	-5%	1,736,650,500	6,185	280,784	14%
2002	-	-	-	-	-	-	-	-

* partial year: 1990- Sept-Dec.; 2001 Jan-April

Trend	Paid Loss			Severity	Paid Loss			Severity
All Yr	2,114,508,250	9,819	215,349		31,549,651,100	155,259	203,076	
91-00	1,991,720,600	9,264	214,996	2.5%	29,514,686,550	147,027	200,743	4.6%
98-00	759,507,950	3,279	231,628	10.1%	10,333,412,300	44,805	230,631	6.0%

Attachment 2a

Florida Hospital Association
Historical Total and Average Malpractice Premium
Largest States and National Totals
(Based on data from Insurance Company Annual Statements as reported by Thomson Financial)

Total Premium Written (x 1,000)

	1996	1997	1998	1999	2000	2001
CA	630,230	639,647	680,203	591,237	586,015	681,870
FL	396,268	400,628	459,279	503,233	536,910	648,091
IL	406,035	393,567	374,458	342,862	395,077	437,276
MA	193,003	167,599	171,015	148,804	163,907	198,437
MI	195,228	180,940	172,163	171,583	176,910	201,101
NJ	277,479	299,391	273,434	285,150	289,981	322,131
NY	784,365	803,188	875,067	867,882	849,702	907,884
OH	263,145	215,009	259,979	241,254	248,819	329,832
PA	206,123	224,506	280,933	273,175	337,851	359,399
TX	327,621	343,216	361,265	342,904	349,567	464,288
All Others	2,348,775	2,234,122	2,260,439	2,381,322	2,487,574	3,040,294
Total	6,028,272	5,901,813	6,168,235	6,149,406	6,422,313	7,590,603

Approximate Overall Average Premium (Total Premium per Doctor)

	1996	1997	1998	1999	2000	2001
CA	8,208	8,148	8,428	7,195	6,965	7,931
FL	12,078	11,749	12,919	13,690	14,081	16,424
IL	13,686	12,958	11,938	10,739	12,053	13,031
MA	8,089	6,814	6,754	5,710	6,118	7,210
MI	9,325	8,483	7,832	7,713	7,770	8,658
NJ	12,376	12,960	11,437	11,627	11,476	12,399
NY	11,846	11,809	12,455	12,081	11,504	11,982
OH	10,431	8,370	9,850	9,025	9,110	11,849
PA	6,184	6,633	8,051	7,772	9,403	9,825
TX	8,950	9,035	9,022	8,346	8,167	10,469
All Others	8,665	8,018	7,842	8,077	8,198	9,759
Total	9,435	8,994	9,089	8,869	9,005	10,373

Attachment 2b

Historical Average Annual Rate Change
Florida by County by Specialty - Physicians only
(Based on data from the Medical Liability Monitor')

American HealthCare Indemnity Ins. Co. (SCPIE Holdings, Inc.)

Specialty	County	1994	1995	1996	1997	1998	1999	2000	2001	2002	94 - 95	95 - 96	96 - 97	97 - 98	98 - 99	99 - 00	00 - 01	01 - 02	All Yr
Internal Medicine	Dade					39,719	34,635	34,635	50,774		-	-	-	-	-12.8%	0.0%	46.6%		7.6%
Internal Medicine	Broward					39,731	29,441	29,441	43,160		-	-	-	-	-25.9%	0.0%	46.6%		2.5%
Internal Medicine	Palm Beach					23,831	20,781	20,781	30,464		-	-	-	-	-12.8%	0.0%	46.6%		7.6%
Internal Medicine	Other					19,860	17,318	17,318	25,388		-	-	-	-	-12.8%	0.0%	46.6%		7.6%
Internal Medicine	Panhandle								21,579		-	-	-	-	-	-	-		-
General Surgery	Dade					87,406	86,357	86,357	126,599		-	-	-	-	-1.2%	0.0%	46.6%		11.8%
General Surgery	Broward					87,387	73,405	73,405	107,611		-	-	-	-	-16.0%	0.0%	46.6%		6.4%
General Surgery	Palm Beach					52,443	51,814	51,814	75,959		-	-	-	-	-1.2%	0.0%	46.6%		11.8%
General Surgery	Other					43,702	43,178	43,178	63,298		-	-	-	-	-1.2%	0.0%	46.6%		11.8%
General Surgery	Panhandle								53,803		-	-	-	-	-	-	-		-
OB/GYN	Dade					119,189	117,759	117,759	172,634		-	-	-	-	-1.2%	0.0%	46.6%		11.8%
OB/GYN	Broward					119,164	100,098	100,098	146,743		-	-	-	-	-16.0%	0.0%	46.6%		6.4%
OB/GYN	Palm Beach					71,513	70,655	70,655	103,580		-	-	-	-	-1.2%	0.0%	46.6%		11.8%
OB/GYN	Other					59,595	58,880	58,880	86,318		-	-	-	-	-1.2%	0.0%	46.6%		11.8%
OB/GYN	Panhandle								73,370		-	-	-	-	-	-	-		-

First Prof. Ins. Co. (FPIC Group)

Specialty	County	1994	1995	1996	1997	1998	1999	2000	2001	2002	94 - 95	95 - 96	96 - 97	97 - 98	98 - 99	99 - 00	00 - 01	01 - 02	All Yr
Internal Medicine	Dade		19,063	21,637	22,698	25,315	28,336	32,744	38,378	56,153	-	13.5%	4.9%	11.5%	11.9%	15.6%	17.2%	46.3%	14.9%
Internal Medicine	Broward		19,063	21,637	19,456	20,526	23,250	30,897	36,213	52,985	-	13.5%	-10.1%	5.5%	13.3%	32.9%	17.2%	46.3%	14.3%
Internal Medicine	Palm Beach		19,063	21,637	19,456	17,105	17,438	20,150	23,617	34,556	-	13.5%	-10.1%	-12.1%	1.9%	15.6%	17.2%	46.3%	5.8%
Internal Medicine	Other	9,955	10,990	12,364	12,971	13,684	14,531	16,792	19,681	28,796	10.4%	12.5%	4.9%	5.5%	6.2%	15.6%	17.2%	46.3%	12.5%
General Surgery	Dade		63,520	67,141	72,635	86,069	99,652	110,068	124,046	174,268	-	5.7%	8.2%	18.5%	15.8%	10.5%	12.7%	40.5%	14.7%
General Surgery	Broward		63,520	67,141	62,259	69,786	81,765	103,859	117,049	164,437	-	5.7%	-7.3%	12.1%	17.2%	27.0%	12.7%	40.5%	14.2%
General Surgery	Palm Beach		63,520	67,141	62,259	58,155	61,324	67,734	76,336	107,242	-	5.7%	-7.3%	-6.6%	5.4%	10.5%	12.7%	40.5%	5.6%
General Surgery	Other	32,048	36,278	38,366	41,506	46,524	51,103	56,445	63,614	89,368	13.2%	5.8%	8.2%	12.1%	9.8%	10.5%	12.7%	40.5%	12.4%
OB/GYN	Dade		113,490	119,959	125,842	140,347	140,685	147,621	166,368	201,376	-	5.7%	4.9%	11.5%	0.2%	4.9%	12.7%	21.0%	7.6%
OB/GYN	Broward		113,490	119,959	107,865	113,795	115,433	139,392	156,983	190,016	-	5.7%	-10.1%	5.5%	1.4%	20.8%	12.6%	21.0%	7.1%
OB/GYN	Palm Beach		113,490	119,959	107,865	94,829	86,575	90,844	102,380	123,924	-	5.7%	-10.1%	-12.1%	-8.7%	4.9%	12.7%	21.0%	-0.9%
OB/GYN	Other	66,005	64,817	68,548	71,910	75,863	72,146	75,703	85,317	103,270	-1.8%	5.8%	4.9%	5.5%	-4.9%	4.9%	12.7%	21.0%	5.5%

ProNational Ins. Co. (ProAssurance)

Specialty	County	1994	1995	1996	1997	1998	1999	2000	2001	2002	94 - 95	95 - 96	96 - 97	97 - 98	98 - 99	99 - 00	00 - 01	01 - 02	All Yr
Internal Medicine	Dade, Broward				21,289	21,289	21,289	26,503	30,478		-	-	-	0.0%	0.0%	24.5%	15.0%		9.8%
Internal Medicine	Palm Beach				18,786	18,786	18,786	23,388	26,896		-	-	-	0.0%	0.0%	24.5%	15.0%		9.8%
Internal Medicine	Other	9,090	9,544	13,111	12,523	12,523	12,523	15,591	17,929		5.0%	37.4%	-4.5%	0.0%	0.0%	24.5%	15.0%		8.8%
General Surgery	Dade				70,949	70,949	70,949	85,383	98,190		-	-	-	0.0%	0.0%	20.3%	15.0%		8.7%
General Surgery	Palm Beach				62,612	62,612	62,612	75,349	86,651		-	-	-	0.0%	0.0%	20.3%	15.0%		8.7%
General Surgery	Other	37,803	40,071	49,071	41,733	41,733	41,733	50,288	57,762		6.0%	22.5%	-15.0%	0.0%	0.0%	20.5%	14.9%		4.4%
OB/GYN	Dade, Broward				106,897	106,897	106,897	128,644	147,941		-	-	-	0.0%	0.0%	20.3%	15.0%		8.7%
OB/GYN	Palm Beach				94,337	94,337	94,337	113,523	130,551		-	-	-	0.0%	0.0%	20.3%	15.0%		8.7%
OB/GYN	Other	63,537	67,985	75,753	62,879	62,879	62,879	75,674	87,025		7.0%	11.4%	-17.0%	0.0%	0.0%	20.3%	15.0%		2.6%

Attachment 2c

Historical Average Annual Rate Change
New York by County by Specialty - Physicians only
(Based on data from the Medical Liability Monitor')

Medical Liability Mutual of New York (MLMIC)

Specialty	County	1994	1995	1996	1997	1998	1999	2000	2001	2002	94 - 95	95 - 96	96 - 97	97 - 98	98 - 99	99 - 00	00 - 01	01 - 02	All Yr
Internal Medicine	New York		18,420	18,420	16,751	16,751	16,751	16,751	16,751	16,751	-	0.0%	-9.1%	0.0%	0.0%	0.0%	0.0%	0.0%	-1.3%
Internal Medicine	Nassau, Suffolk		23,804	23,804	21,648	21,648	21,648	21,648	21,648	21,648	-	0.0%	-9.1%	0.0%	0.0%	0.0%	0.0%	0.0%	-1.3%
Internal Medicine	Upstate New York		8,082	8,082	6,762	6,762	6,762	6,102	6,102	6,102	-	0.0%	-16.3%	0.0%	0.0%	-9.8%	0.0%	0.0%	-4.3%
General Surgery	New York		50,835	50,835	46,230	46,230	46,230	48,542	48,542	50,970	-	0.0%	-9.1%	0.0%	0.0%	5.0%	0.0%	5.0%	-0.1%
General Surgery	Nassau, Suffolk		65,696	65,696	59,746	59,746	59,746	62,733	62,733	65,870	-	0.0%	-9.1%	0.0%	0.0%	5.0%	0.0%	5.0%	-0.1%
General Surgery	Upstate New York		22,304	22,304	18,661	18,661	18,661	18,624	18,616	19,547	-	0.0%	-16.3%	0.0%	0.0%	-0.2%	0.0%	5.0%	-2.2%
OB/GYN	New York		98,214	98,214	89,317	89,317	89,317	89,317	89,317	89,317	-	0.0%	-9.1%	0.0%	0.0%	0.0%	0.0%	0.0%	-1.3%
OB/GYN	Nassau, Suffolk		126,925	126,925	115,429	115,429	115,429	115,429	115,429	115,431	-	0.0%	-9.1%	0.0%	0.0%	0.0%	0.0%	0.0%	-1.3%
OB/GYN	Upstate New York		43,092	43,092	36,054	36,054	36,054	34,251	34,253	34,253	-	0.0%	-16.3%	0.0%	0.0%	-5.0%	0.0%	0.0%	-3.4%

Group Council Mutual Ins. Co.

Specialty	County	1994	1995	1996	1997	1998	1999	2000	2001	2002	94 - 95	95 - 96	96 - 97	97 - 98	98 - 99	99 - 00	00 - 01	01 - 02	All Yr
Internal Medicine	Manhattan, Orange, Ulster		22,090	22,090	22,090	22,090	22,090	24,299			-	0.0%	0.0%	0.0%	0.0%	10.0%	-		1.4%
Internal Medicine	Bronx, Brooklyn, Queens, Staten Island, Rockland, Sullivan		24,956	24,956	24,956	24,956	24,956	27,452			-	0.0%	0.0%	0.0%	0.0%	10.0%	-		1.4%
Internal Medicine	Nassau, Suffolk		28,548	28,548	28,548	28,548	28,548	31,403			-	0.0%	0.0%	0.0%	0.0%	10.0%	-		1.4%
Internal Medicine	Remainder Of State		12,916	12,916	12,916	12,916	12,916	14,208			-	0.0%	0.0%	0.0%	0.0%	10.0%	-		1.4%
General Surgery	Manhattan, Orange, Ulster		65,909	65,909	65,909	65,909	65,909	72,500			-	0.0%	0.0%	0.0%	0.0%	10.0%	-		1.4%
General Surgery	Bronx, Brooklyn, Queens, Staten Island, Rockland, Sullivan		74,459	74,459	74,459	74,459	74,459	81,905			-	0.0%	0.0%	0.0%	0.0%	10.0%	-		1.4%
General Surgery	Nassau, Suffolk		85,178	85,178	85,178	85,178	85,178	93,696			-	0.0%	0.0%	0.0%	0.0%	10.0%	-		1.4%
General Surgery	Remainder Of State		38,537	38,537	38,537	38,537	38,537	42,391			-	0.0%	0.0%	0.0%	0.0%	10.0%	-		1.4%
OB/GYN	Manhattan, Orange, Ulster		112,178	112,178	112,178	112,178	112,178	123,396			-	0.0%	0.0%	0.0%	0.0%	10.0%	-		1.4%
OB/GYN	Bronx, Brooklyn, Queens, Staten Island, Rockland, Sullivan		126,760	126,730	126,730	126,730	126,730	139,403			-	0.0%	0.0%	0.0%	0.0%	10.0%	-		1.4%
OB/GYN	Nassau, Suffolk		144,973	144,973	144,973	144,973	144,973	159,470			-	0.0%	0.0%	0.0%	0.0%	10.0%	-		1.4%
OB/GYN	Remainder Of State		65,591	65,591	65,591	65,591	65,591	72,150			-	0.0%	0.0%	0.0%	0.0%	10.0%	-		1.4%

Attachment 2d

Historical Average Annual Rate Change
Texas by County by Specialty - Physicians only
(Based on data from the Medical Liability Monitor')

Texas Medical Liability Trust

Specialty	County	1994	1995	1996	1997	1998	1999	2000	2001	2002	94 - 95	95 - 96	96 - 97	97 - 98	98 - 99	99 - 00	00 - 01	01 - 02	All Yr
Internal Medicine	Lowest; Amarillo, Lubbock			5,889	6,478	6,478	6,478	8,072	11,077	12,680	-	-	10.0%	0.0%	0.0%	24.6%	37.2%	14.5%	16.0%
Internal Medicine	Highest; Brownsville, Laredo, El Paso			9,555	11,466	12,040	12,642	18,783	25,563	26,334	-	-	20.0%	5.0%	5.0%	48.6%	36.1%	3.0%	21.5%
General Surgery	Lowest, Amarillo, Lubbock			18,042	17,592	16,712	16,712	21,816	29,156	34,144	-	-	-2.5%	-5.0%	0.0%	30.5%	33.6%	17.1%	16.2%
General Surgery	Highest; Brownsville, Laredo, El Paso			29,534	32,488	34,762	36,500	50,911	67,555	71,200	-	-	10.0%	7.0%	5.0%	39.5%	32.7%	5.4%	19.5%
OB/GYN	Lowest, Amarillo, Lubbock			32,393	29,154	27,696	26,311	30,537	38,260	42,710	-	-	-10.0%	-5.0%	-5.0%	16.1%	25.3%	11.6%	9.0%
OB/GYN	Highest, Brownsville, Laredo, El Paso			54,951	57,697	57,697	57,697	73,660	91,894	92,326	-	-	5.0%	0.0%	0.0%	27.7%	24.8%	0.5%	12.1%

Florida Hospital Association Attachment 3b

Historical Percentage Split of Physician losses between Economic Damages and Non-Economic Damages

Total Florida

(Based on data from the Florida Database)

	(1)	(2) (1) / (13)	(3)	(4) (3) / (13)	(5)	(6) (5) / (13)	(7)	(8) (7) / (13)	(9) (1)+(3)+(5)+(7)
	Physician								
Claim Close Year	Economic - Medical [1] $	% of Total	Economic - Wage [1] $	% of Total	Economic - Other [1] $	% of Total	Non-Economic $	% of Total	Total Physician Losses With Known Split
(Blank)	-	-	-	-	-	-	-	-	-
1973	-	-	-	-	-	-	-	-	-
1974	-	-	-	-	-	-	-	-	-
1975	-	-	-	-	-	-	-	-	-
1976	-	-	-	-	-	-	-	-	-
1977	-	-	-	-	-	-	-	-	-
1978	-	-	-	-	-	-	-	-	-
1979	-	-	-	-	-	-	-	-	-
1980	-	-	-	-	-	-	-	-	-
1981	-	-	-	-	-	-	150,000	1.000	150,000
1982	-	-	-	-	-	-	970,000	1.000	970,000
1983	30,730	0.235	-	-	-	-	100,000	0.765	130,730
1984	80,943	0.065	35,000	0.028	1,357	0.001	1,118,500	0.905	1,235,800
1985	916,297	0.073	323,035	0.026	26,839	0.002	11,359,373	0.900	12,625,544
1986	4,120,053	0.084	946,195	0.019	325,019	0.007	43,538,114	0.890	48,929,381
1987	6,386,405	0.102	1,266,716	0.020	498,684	0.008	54,252,643	0.869	62,404,448
1988	10,154,605	0.117	2,253,093	0.026	475,250	0.005	73,720,050	0.851	86,602,998
1989	14,365,667	0.142	3,934,739	0.039	914,743	0.009	82,132,473	0.810	101,347,622
1990	20,169,164	0.073	5,911,745	0.021	424,424	0.002	250,719,453	0.904	277,224,786
1991	18,409,331	0.143	3,485,290	0.027	587,903	0.005	105,975,677	0.825	128,458,201
1992	11,803,695	0.104	1,166,294	0.010	494,299	0.004	100,273,225	0.882	113,737,513
1993	16,527,206	0.147	2,158,383	0.019	758,216	0.007	92,738,752	0.827	112,182,557
1994	20,590,521	0.169	5,175,926	0.042	1,269,834	0.010	94,779,036	0.778	121,815,317
1995	32,567,159	0.189	10,939,379	0.064	1,647,271	0.010	127,071,933	0.738	172,225,742
1996	35,619,074	0.158	5,177,377	0.023	569,548	0.003	183,507,542	0.816	224,873,541
1997	27,979,770	0.141	12,301,375	0.062	6,252,919	0.031	152,395,623	0.766	198,929,687
1998	45,191,353	0.224	5,337,343	0.026	8,612,596	0.043	142,516,788	0.707	201,658,080
1999	32,299,981	0.166	11,565,804	0.060	4,067,104	0.021	146,107,760	0.753	194,040,649
2000	37,229,892	0.190	13,518,516	0.069	1,667,541	0.009	143,563,787	0.733	195,979,736
2001	31,843,021	0.170	9,603,659	0.051	10,579,353	0.056	135,566,375	0.723	187,592,408
2002	6,430,079	0.131	3,365,384	0.068	250,298	0.005	39,100,667	0.796	49,146,428
Total	372,714,946	0.150	98,465,253	0.040	39,423,198	0.016	1,981,657,771	0.795	2,492,261,168

Notes: [1] The economic losses shown here exclude the 'Estimated Future' payments.
[2] Only the expenses corresponding to records with an economic/non-economic split are shown here.

Historical Average Annual Rate Change

California by County by Specialty - Physicians only

(Based on data from the Medical Liability Monitor')

Attachment 2a

Clarendon National Insurance Co.

Specialty	County	1994	1995	1996	1997	1998	1999	2000	2001	2002	94 - 95	95 - 96	96 - 97	97 - 98	98 - 99	99 - 00	00 - 01	01 - 02	All Yr
Internal Medicine	Riverside, San Bernardion						9,572	9,572	9,572		-	-	-	-	-	0.0%	0.0%		0.0%
Internal Medicine	Los Angeles, Orange						8,946	8,946	8,946		-	-	-	-	-	0.0%	0.0%		0.0%
Internal Medicine	San Diego, Imperial						7,604	7,604	7,604		-	-	-	-	-	0.0%	0.0%		0.0%
	Kern, San Luis Obispo, Santa Barbara, Ventura						6,262	6,262	6,262		-	-	-	-	-	0.0%	0.0%		0.0%
General Surgery	Riverside, San Bernardion						25,310	25,310	25,310		-	-	-	-	-	0.0%	0.0%		0.0%
General Surgery	Los Angeles, Orange						23,655	23,655	23,655		-	-	-	-	-	0.0%	0.0%		0.0%
General Surgery	San Diego, Imperial						20,106	20,106	20,106		-	-	-	-	-	0.0%	0.0%		0.0%
	Kern, San Luis Obispo, Santa Barbara, Ventura						16,550	16,558	16,558		-	-	-	-	-	0.0%	0.0%		0.0%
OB/GYN	Riverside, San Bernardion						56,330	56,330	56,330		-	-	-	-	-	0.0%	0.0%		0.0%
OB/GYN	Los Angeles, Orange						52,645	52,645	52,645		-	-	-	-	-	0.0%	0.0%		0.0%
OB/GYN	San Diego, Imperial						44,748	44,748	44,748		-	-	-	-	-	0.0%	0.0%		0.0%
	Kern, San Luis Obispo, Santa Barbara, Ventura						36,851	36,851	36,851		-	-	-	-	-	0.0%	0.0%		0.0%

SCPIE Indemnity Co. (SCPIE Holdings, Inc)

Specialty	County	1994	1995	1996	1997	1998	1999	2000	2001	2002									
Internal Medicine	Los Angeles		8,452	8,656	9,084	9,084	10,976	10,976	12,060	12,668	-	2.4%	4.9%	0.0%	20.8%	0.0%	9.9%	5.0%	6.4%
Internal Medicine	Orange		8,452	8,656	9,084	9,084	10,976	10,976	12,428	13,872	-	2.4%	4.9%	0.0%	20.8%	0.0%	13.1%	9.9%	7.5%
Internal Medicine	Riverside		8,452	9,084	9,752	9,752	12,376	12,376	14,900	15,644	-	7.5%	7.4%	0.0%	26.9%	0.0%	20.4%	5.0%	9.6%
Internal Medicine	San Bernardino		8,452	9,084	9,752	9,752	12,376	12,376	14,232	14,938	-	7.5%	7.4%	0.0%	26.9%	0.0%	15.0%	4.9%	8.9%
Internal Medicine	Kern, Ventura		6,772	7,376	7,744	7,744	8,920	8,920	10,252	10,764	-	8.9%	5.0%	0.0%	15.2%	0.0%	14.9%	5.0%	6.7%
Internal Medicine	Santa Barbara		6,772	7,376	7,744	7,744	8,920	8,920	9,804	10,288	-	8.9%	5.0%	0.0%	15.2%	0.0%	9.9%	4.9%	6.0%
Internal Medicine	San Luis Obispo		6,772	7,376	7,744	7,744	8,920	8,920	7,948	8,736	-	8.9%	5.0%	0.0%	15.2%	0.0%	-10.9%	9.9%	3.3%
Internal Medicine	San Diego, Imperial		6,772	7,376	7,964	7,964	9,616	9,616	11,052	11,604	-	8.9%	8.0%	0.0%	20.7%	0.0%	14.9%	5.0%	8.1%
Internal Medicine	All other counties		5,680	6,064	6,592	6,582	7,948	7,948	7,948	8,736	-	6.8%	8.7%	-0.2%	20.8%	0.0%	0.0%	9.9%	6.3%
General Surgery	Los Angeles		28,460	29,164	30,604	30,604	32,136	32,136	35,316	37,068	-	2.5%	4.9%	0.0%	5.0%	0.0%	9.9%	5.0%	3.6%
General Surgery	Orange		28,460	29,164	30,604	30,604	32,136	32,136	37,004	40,684	-	2.5%	4.9%	0.0%	5.0%	0.0%	15.1%	9.9%	4.7%
General Surgery	Riverside		28,460	30,648	32,940	32,940	36,332	36,332	43,832	46,008	-	7.7%	7.5%	0.0%	10.3%	0.0%	20.6%	5.0%	6.8%
General Surgery	San Bernardino		28,460	30,648	32,940	32,940	36,332	36,332	41,812	43,892	-	7.7%	7.5%	0.0%	10.3%	0.0%	15.1%	5.0%	6.1%
General Surgery	Kern, Ventura		22,680	24,728	25,952	25,952	25,968	25,968	29,884	31,372	-	9.0%	4.9%	0.0%	0.1%	0.0%	15.1%	5.0%	3.9%
General Surgery	Santa Barbara		22,680	24,728	25,952	25,952	25,968	25,968	28,544	29,948	-	9.0%	4.9%	0.0%	0.1%	0.0%	9.9%	4.9%	3.2%
General Surgery	San Luis Obispo		22,680	24,728	25,952	25,952	25,968	25,968	25,048	25,324	-	9.0%	4.9%	0.0%	0.1%	0.0%	-11.2%	9.9%	0.5%
General Surgery	San Diego, Imperial		22,680	24,728	26,704	26,704	28,064	28,064	32,300	33,884	-	9.0%	8.0%	0.0%	5.1%	0.0%	15.1%	4.9%	5.3%
General Surgery	All other counties		18,872	20,172	21,968	21,968	23,048	23,048	23,048	25,324	-	6.9%	8.9%	0.0%	4.9%	0.0%	0.0%	9.9%	3.5%
OB/GYN	Los Angeles		52,552	53,864	56,505	56,505	52,532	52,532	57,740	60,584	-	2.5%	4.9%	0.0%	-7.0%	0.0%	9.9%	4.9%	1.3%
OB/GYN	Orange		52,552	53,864	56,505	56,505	52,532	52,532	60,496	66,532	-	2.5%	4.9%	0.0%	-7.0%	0.0%	15.2%	10.0%	2.3%
OB/GYN	Riverside		52,552	56,600	60,856	60,856	59,440	59,440	71,728	75,276	-	7.7%	7.5%	0.0%	-2.3%	0.0%	20.7%	4.9%	4.4%
OB/GYN	San Bernardino		52,552	56,600	60,856	60,856	59,440	59,440	68,416	71,820	-	7.7%	7.5%	0.0%	-2.3%	0.0%	15.1%	5.0%	3.7%
OB/GYN	Kern, Ventura		44,824	45,616	47,860	47,860	42,396	42,396	48,812	51,236	-	1.8%	4.9%	0.0%	-11.4%	0.0%	15.1%	5.0%	0.9%
OB/GYN	Santa Barbara		44,824	45,616	47,860	47,860	42,396	42,396	46,604	48,908	-	1.8%	4.9%	0.0%	-11.4%	0.0%	9.9%	4.9%	0.3%
OB/GYN	San Luis Obispo		44,824	45,616	47,860	47,860	42,396	42,396	37,596	41,320	-	1.8%	4.9%	0.0%	-11.4%	0.0%	-11.3%	9.9%	-2.4%
OB/GYN	San Diego, Imperial		41,824	45,616	49,272	49,272	45,848	45,848	52,772	55,372	-	9.1%	8.0%	0.0%	-6.9%	0.0%	15.1%	4.9%	2.9%
OB/GYN	All other counties		34,736	37,148	40,476	40,476	37,596	37,596	37,596	41,320	-	6.9%	9.0%	0.0%	-7.1%	0.0%	0.0%	9.9%	1.2%

Florida Hospital Association Attachment 3c

Historical Percentage Split of Malpractice losses between Economic Damages and Non-Economic Damages

Total Texas

(Based on data from the Texas Database)

	(1)	(2) (1) / (13)	(3)	(4) (3) / (13)	(5)	(6) (5) / (13)	(7) (1)+(3)+(5)
Claim Close Year	Economic $	% of Total	Non-Economic $	% of Total	Other $	% of Total	Total Losses With Known Split
(Blank)	-	-	-	-	-	-	-
1973	-	-	-	-	-	-	-
1974	-	-	-	-	-	-	-
1975	-	-	-	-	-	-	-
1976	-	-	-	-	-	-	-
1977	-	-	-	-	-	-	-
1978	-	-	-	-	-	-	-
1979	-	-	-	-	-	-	-
1980	-	-	-	-	-	-	-
1981	-	-	-	-	-	-	-
1982	-	-	-	-	-	-	-
1983	-	-	-	-	-	-	-
1984	-	-	-	-	-	-	-
1985	-	-	-	-	-	-	-
1986	-	-	-	-	-	-	-
1987	-	-	-	-	-	-	-
1988	-	-	-	-	-	-	-
1989	-	-	-	-	-	-	-
1990	81,857,442	0.350	131,306,548	0.561	21,046,375	0.090	234,210,365
1991	43,408,055	0.310	79,376,366	0.567	17,274,528	0.123	140,058,949
1992	41,722,861	0.332	72,384,896	0.576	11,623,437	0.092	125,731,194
1993	48,127,504	0.355	74,470,992	0.549	13,157,667	0.097	135,756,163
1994	34,654,921	0.291	74,514,309	0.627	9,725,092	0.082	118,894,322
1995	45,972,892	0.261	98,095,028	0.556	32,315,799	0.183	176,383,719
1996	48,050,944	0.316	92,077,645	0.606	11,760,487	0.077	151,889,076
1997	40,209,761	0.291	86,071,853	0.623	11,979,625	0.087	138,261,239
1998	37,539,574	0.235	96,181,506	0.603	25,682,786	0.161	159,403,866
1999	53,921,877	0.262	136,711,301	0.665	14,847,634	0.072	205,480,812
2000	73,077,464	0.292	151,343,740	0.605	25,939,767	0.104	250,360,971
2001	-	-	-	-	-	-	-
2002	-	-	-	-	-	-	-
Total	548,543,295	0.299	1,092,534,184	0.595	195,353,197	0.106	1,836,430,676

Florida Hospital Association Attachment 3a

Historical Percentage Split of Hospital losses between Economic Damages and Non-Economic Damages

Total Florida

(Based on data from the Florida Database)

	(1)	(2) (1) / (9)	(3)	(4) (3) / (9)	(5)	(6) (5) / (9)	(7)	(8) (7) / (9)	(9) (1)+(3)+(5)+(7)
	Hospital								
Claim Close Year	Economic - Medical [1] $	% of Total	Economic - Wage [1] $	% of Total	Economic - Other [1] $	% of Total	Non-Economic $	% of Total	Total Hospital Losses With Known Split
(Blank)	-	-	-	-	-	-	-	-	-
1973	-	-	-	-	-	-	-	-	-
1974	-	-	-	-	-	-	-	-	-
1975	-	-	-	-	-	-	-	-	-
1976	-	-	-	-	-	-	-	-	-
1977	-	-	-	-	-	-	-	-	-
1978	-	-	-	-	-	-	-	-	-
1979	-	-	-	-	-	-	-	-	-
1980	-	-	-	-	-	-	-	-	-
1981	-	-	-	-	-	-	-	-	-
1982	-	-	-	-	-	-	-	-	-
1983	-	-	-	-	-	-	-	-	-
1984	2,282	1.000	-	-	-	-	-	-	2,282
1985	406,820	0.216	-	-	1,418	0.001	1,470,927	0.783	1,879,165
1986	3,401,325	0.326	250,133	0.024	82,315	0.008	6,705,021	0.642	10,438,814
1987	14,334,479	0.432	308,617	0.009	915,357	0.028	17,640,118	0.531	33,198,571
1988	2,986,391	0.205	142,458	0.010	42,298	0.003	11,405,551	0.782	14,576,698
1989	3,933,501	0.204	1,209,436	0.063	14,046	0.001	14,119,749	0.732	19,276,732
1990	3,724,374	0.133	346,527	0.012	30,172	0.001	23,857,401	0.853	27,958,474
1991	2,288,806	0.165	230,838	0.017	51,450	0.004	11,294,223	0.815	13,865,317
1992	4,616,249	0.206	396,407	0.018	551,894	0.025	16,819,378	0.751	22,383,928
1993	6,558,387	0.324	1,071,236	0.053	1,750	0.000	12,613,709	0.623	20,245,082
1994	4,476,157	0.142	1,190,663	0.038	415,996	0.013	25,437,086	0.807	31,519,902
1995	11,811,965	0.249	1,188,191	0.025	548,222	0.012	33,834,771	0.714	47,383,149
1996	16,985,281	0.273	1,981,508	0.032	626,069	0.010	42,543,783	0.685	62,136,641
1997	11,745,039	0.137	669,047	0.008	398,308	0.005	73,096,283	0.851	85,908,677
1998	14,054,049	0.172	2,128,213	0.026	416,061	0.005	65,292,620	0.797	81,890,943
1999	13,944,159	0.161	735,951	0.009	1,035,197	0.012	70,642,588	0.818	86,357,895
2000	9,748,833	0.121	1,761,136	0.022	232,130	0.003	68,663,170	0.854	80,405,269
2001	10,770,165	0.164	4,950,482	0.076	348,992	0.005	49,414,903	0.755	65,484,542
2002	3,418,238	0.189	603,013	0.033	26,215	0.001	14,026,931	0.776	18,074,397
Total	139,206,500	0.193	19,163,876	0.027	5,737,890	0.008	538,878,212	0.773	722,986,478

Notes: [1] The economic losses shown here exclude the 'Estimated Future' payments.
[2] Only the expenses corresponding to records with an economic/non-economic split are shown here.

Florida Hospital Association
Historical Average Annual Increase in Economic & Non-Economic Damages for Medical Liability Claims
Texas Cases With Indemnity Categorized
(Based on data from theTexas Database)

Attachment 4c

	(1)	(2)	(3) (1) / (2)	(4) (3) / Prior (3)	(5)	(6)	(7) (5) / (6)	(8) (7) / Prior (7)
	Non-Economic				Economic			
Claim Close Year	Total Paid Non-Economic	# of closed claims with known Econ. / Non-Econ. Split	Average Paid Non-Economic	% of Annual Increase in Average Paid Non-Economic	Total Paid Economic	# of closed claims with known Econ. / Non-Econ. Split	Average Paid Economic	% of Annual Increase in Average Paid Economic
(Blank)	-	-	-		-	-	-	
1973	-	-	-	0%	-	-	-	0%
1974	-	-	-	0%	-	-	-	0%
1975	-	-	-	0%	-	-	-	0%
1976	-	-	-	0%	-	-	-	0%
1977	-	-	-	0%	-	-	-	0%
1978	-	-	-	0%	-	-	-	0%
1979	-	-	-	0%	-	-	-	0%
1980	-	-	-	0%	-	-	-	0%
1981	-	-	-	0%	-	-	-	0%
1982	-	-	-	0%	-	-	-	0%
1983	-	-	-	0%	-	-	-	0%
1984	-	-	-	0%	-	-	-	0%
1985	-	-	-	0%	-	-	-	0%
1986	-	-	-	0%	-	-	-	0%
1987	-	-	-	0%	-	-	-	0%
1988	-	-	-	0%	-	-	-	0%
1989	-	-	-	0%	-	-	-	0%
1990	131,306,548	461	284,830	0%	81,857,442	461	177,565	0%
1991	79,376,366	369	215,112	-24%	43,408,055	369	117,637	-34%
1992	72,384,896	382	189,489	-12%	41,722,861	382	109,222	-7%
1993	74,470,992	346	215,234	14%	48,127,504	346	139,097	27%
1994	74,514,309	371	200,847	-7%	34,654,921	371	93,409	-33%
1995	98,095,028	414	236,945	18%	45,972,892	414	111,046	19%
1996	92,077,645	360	255,771	8%	48,050,944	360	133,475	20%
1997	86,071,853	321	268,137	5%	40,209,761	321	125,264	-6%
1998	96,181,506	320	300,567	12%	37,539,574	320	117,311	-6%
1999	136,711,301	378	361,670	20%	53,921,877	378	142,650	22%
2000	151,343,740	346	437,410	21%	73,077,464	346	211,207	48%
2001	-	-	-	0%	-	-	-	
2002	-	-	-	0%	-	-	-	0%
Trend								
All Yr	1,092,534,184	4,068	268,568		548,543,295	4,068	134,843	
91-00	470,308,400	1,365	344,548	8.5%	204,748,676	1,365	149,999	4.6%
98-00	384,236,547	1,044	368,043	20.6%	164,538,915	1,044	157,604	34.2%

Florida Hospital Association
Historical Average Annual Increase in Non-Economic Damages for Medical Liability Claims
Total Florida
(Based on data from the Florida Database)

Attachment 4a

	(1)	(2)	(3) (1) / (2)	(4) (3) / Prior (3)	(5)	(6)	(7) (5) / (6)	(8) (7) / Prior (7)
	Hospital				Physician			
Claim Close Year	Total Paid Non-Economic	# of closed claims with known Econ. / Non-Econ. Split	Average Paid Non-Economic	% of Annual Increase in Average Paid Non-Economic	Total Paid Non-Economic	# of closed claims with known Econ. / Non-Econ. Split	Average Paid Non-Economic	% of Annual Increase in Average Paid Non-Economic
(Blank)	-	-	0		-	-	0	
1973	-	-	0	0%	-	-	0	0%
1974	-	-	0	0%	-	-	0	0%
1975	-	-	0	0%	-	-	0	0%
1976	-	-	0	0%	-	-	0	0%
1977	-	-	0	0%	-	-	0	0%
1978	-	-	0	0%	-	-	0	0%
1979	-	-	0	0%	-	-	0	0%
1980	-	-	0	0%	-	-	0	0%
1981	-	-	0	0%	-	-	0	0%
1982	-	-	0	0%	150,000	1	150,000	0%
1983	-	-	0	0%	970,000	2	485,000	223%
1984	-	1	0	0%	100,000	2	50,000	-90%
1985	1,470,927	35	42,026	0%	1,118,500	9	124,278	149%
1986	6,705,021	115	58,305	39%	11,359,373	190	59,786	-52%
1987	17,640,118	140	126,001	116%	43,538,114	399	109,118	83%
1988	11,405,551	194	58,792	-53%	54,252,643	470	115,431	6%
1989	14,119,749	163	86,624	47%	73,720,050	631	116,831	1%
1990	23,857,401	165	144,590	67%	82,132,473	672	122,221	5%
1991	11,294,223	154	73,339	-49%	250,719,453	568	441,407	261%
1992	16,819,378	132	127,420	74%	105,975,677	644	164,559	-63%
1993	12,613,709	119	105,998	-17%	100,273,225	570	175,918	7%
1994	25,437,086	136	187,037	76%	92,738,752	589	157,451	-10%
1995	33,834,771	192	176,223	-6%	94,779,036	636	149,024	-5%
1996	42,543,783	247	172,242	-2%	127,071,933	739	171,951	15%
1997	73,096,283	404	180,931	5%	183,507,542	866	211,902	23%
1998	65,292,620	385	169,591	-6%	152,395,623	767	198,691	-6%
1999	70,642,588	372	189,899	12%	142,516,788	838	170,068	-14%
2000	68,663,170	322	213,240	12%	146,107,760	694	210,530	24%
2001	49,414,903	328	150,655	-29%	143,563,787	709	202,488	-4%
2002	14,026,931	85	165,023	10%	135,566,375	684	198,196	-2%
Trend				Severity				Severity
All Yr	558,878,212	3,689	151,499		1,981,657,771	10,866	182,372	
91-01	469,652,514	2,791	168,274	6.8%	1,424,496,498	7,736	184,139	2.6%
98-01	254,013,281	1,407	180,535	-2.4%	567,754,710	2,925	194,104	4.3%

Florida Hospital Association
Historical Average Annual Increase in Loss and Defense Costs for Medical Liability Claims
Total Texas
(Based on data from theTexas Database)

Attachment 4d

	(1)	(2)	(3) (1) / (2)	(4) (3) / Prior (3)	(5)	(6)	(7) (5) / (6)	(8) (7) / Prior (7)
	Total Loss				Defense Costs			
Claim Close Year	Total Paid Loss	Number of Cases	Average Paid Loss	% of Annual Increase in Average Paid Loss	Total Defense Costs	Number of Cases	Average Defense Cost	% of Annual Increase in Average Defense Cost
(Blank)	-	-	-		-	-	-	
1973	-	-	-	0%	-	-	-	0%
1974	-	-	-	0%	-	-	-	0%
1975	-	-	-	0%	-	-	-	0%
1976	-	-	-	0%	-	-	-	0%
1977	-	-	-	0%	-	-	-	0%
1978	-	-	-	0%	-	-	-	0%
1979	-	-	-	0%	-	-	-	0%
1980	-	-	-	0%	-	-	-	0%
1981	-	-	-	0%	-	-	-	0%
1982	-	-	-	0%	-	-	-	0%
1983	-	-	-	0%	-	-	-	0%
1984	-	-	-	0%	-	-	-	0%
1985	-	-	-	0%	-	-	-	0%
1986	-	-	-	0%	-	-	-	0%
1987	-	-	-	0%	-	-	-	0%
1988	-	-	-	0%	-	-	-	0%
1989	-	-	-	0%	-	-	-	0%
1990	398,718,110	971	410,626	0%	30,656,563	971	31,572	0%
1991	269,148,834	889	302,755	-26%	30,941,841	889	34,805	10%
1992	343,975,733	1,080	318,496	5%	36,050,463	1,080	33,380	-4%
1993	323,809,003	1,013	319,654	0%	35,041,948	1,013	34,592	4%
1994	285,040,061	976	292,049	-9%	34,090,243	976	34,929	1%
1995	388,894,324	1,154	336,997	15%	42,939,473	1,154	37,209	7%
1996	332,172,328	1,108	299,795	-11%	42,955,247	1,108	38,768	4%
1997	378,984,705	1,147	330,414	10%	48,705,737	1,147	42,464	10%
1998	384,269,474	1,069	359,466	9%	49,042,964	1,069	45,877	8%
1999	478,011,332	1,170	408,557	14%	69,414,879	1,170	59,329	29%
2000	554,031,851	1,249	443,580	9%	68,934,714	1,249	55,192	-7%
2001	-	-	-	0%	-	-	-	
2002	-	-	-	0%	-	-	-	0%
Trend				Severity				Severity
All Yr	4,137,055,955	11,826	349,827		488,774,072	11,826	41,330	
91-00	1,795,297,562	4,635	387,335	3.7%	236,098,294	4,635	50,938	6.4%
98-00	1,416,312,857	3,488	406,053	11.1%	187,392,557	3,488	53,725	9.7%

Florida Hospital Association
Historical Average Annual Increase in Economic Damages for Medical Liability Claims
Total Florida
(Based on data from the Florida Database)

Attachment 4b

	(1)	(2)	(3) (1) / (2)	(4) (3) / Prior (3)	(5)	(6)	(7) (5) / (6)	(8) (7) / Prior (7)
	Hospital				Physician			
Claim Close Year	Total Paid Economic	# of closed claims with known Econ. / Non-Econ. Split	Average Paid Economic	% of Annual Increase in Average Paid Economic	Total Paid Economic	# of closed claims with known Econ. / Non-Econ. Split	Average Paid Economic	% of Annual Increase in Average Paid Economic
(Blank)	-	-	0		-	-	0	
1973	-	-	0	0%	-	-	0	0%
1974	-	-	0	0%	-	-	0	0%
1975	-	-	0	0%	-	-	0	0%
1976	-	-	0	0%	-	-	0	0%
1977	-	-	0	0%	-	-	0	0%
1978	-	-	0	0%	-	-	0	0%
1979	-	-	0	0%	-	-	0	0%
1980	-	-	0	0%	-	-	0	0%
1981	-	-	0	0%	-	1	0	0%
1982	-	-	0	0%	-	2	0	0%
1983	-	-	0	0%	30,730	2	15,365	0%
1984	2,282	1	2,282	0%	117,300	9	13,033	-15%
1985	408,238	35	11,664	411%	1,266,171	190	6,664	-49%
1986	3,733,793	115	32,468	178%	5,391,267	399	13,512	103%
1987	15,558,453	140	111,132	242%	8,151,805	470	17,344	28%
1988	3,171,147	194	16,346	-85%	12,882,948	631	20,417	18%
1989	3,156,983	163	31,638	94%	19,213,149	672	28,594	40%
1990	4,101,073	165	24,855	-21%	26,505,333	568	46,664	63%
1991	2,571,094	154	16,695	-33%	22,482,524	644	34,911	-25%
1992	5,564,550	132	42,156	152%	13,464,288	570	23,622	-32%
1993	7,631,373	119	64,129	52%	19,443,805	589	33,012	40%
1994	6,082,816	136	44,727	-30%	27,036,281	636	42,510	29%
1995	13,548,378	192	70,564	58%	45,153,809	739	61,101	44%
1996	19,592,858	247	79,323	12%	41,365,999	866	47,767	-22%
1997	12,812,394	404	31,714	-60%	46,534,066	767	60,670	27%
1998	16,598,323	385	43,113	36%	59,141,292	838	70,574	16%
1999	15,715,307	372	42,245	-2%	47,932,889	694	69,068	-2%
2000	11,742,099	322	36,466	-14%	52,415,949	709	73,929	7%
2001	16,069,639	328	48,993	34%	52,026,033	684	76,061	3%
2002	4,047,466	85	47,617	-3%	10,045,761	186	54,009	-29%
Trend								
All Yr	164,108,266	3,689	44,486		510,603,397	10,866	46,991	
91-01	127,928,831	2,791	45,836	2.5%	426,996,933	7,736	55,196	11.2%
98-01	60,125,368	1,407	42,733	2.4%	211,516,163	2,925	72,313	3.0%

Florida Hospital Association
Historical Percentage of Florida Paid Losses by Territory
(Based on data from the Florida Database)

Attachment 6b

Claim Close Year	(1)	(2) (1) / (7)	(3)	(4) (3) / (7)	(5)	(6) (5) / (7)	(7) (1) + (3) + (5)	(8)	(9) (8) / (14)	(10)	(11) (10) / (14)	(12)	(13) (12) / (14)	(14) (8) + (10) + (12)
	Hospital							Physician						
	Dade and Broward		Palm Beach, Hillsborough Pinellas, Orange, Duval		Remainder of Florida		Total Closed With Payment Claims	Dade and Broward		Palm Beach, Hillsborough Pinellas, Orange, Duval		Remainder of Florida		Total Closed With Payment Claims
	$	% of Total	$	% of Total	$	% of Total		$	% of Total	$	% of Total	$	% of Total	
(Blank)	-	0%	-	0%	-	0%	-	-	0%	-	0%	-	0%	-
1973	-	0%	-	0%	-	0%	-	131,050	99%	1,000	1%	-	0%	132,050
1974	-	0%	-	0%	-	0%	-	4,939	3%	138,167	80%	30,500	18%	173,606
1975	-	0%	-	0%	-	0%	-	4,698,033	43%	4,673,663	43%	1,556,714	14%	10,928,410
1976	450	100%	-	0%	-	0%	450	3,518,064	43%	2,502,908	30%	2,207,933	27%	8,228,905
1977	-	0%	-	0%	-	0%	-	3,844,330	32%	4,444,102	37%	3,736,244	31%	12,024,676
1978	2,500	100%	-	0%	-	0%	2,500	6,482,755	54%	3,398,332	28%	2,192,608	18%	12,073,695
1979	-	0%	-	0%	-	0%	-	6,113,050	44%	4,843,861	35%	2,994,246	21%	13,951,157
1980	-	0%	-	0%	-	0%	-	13,390,831	48%	12,265,551	44%	2,374,053	8%	28,030,435
1981	-	0%	-	0%	-	0%	-	18,999,803	50%	11,387,264	30%	7,835,512	20%	38,222,579
1982	-	0%	-	0%	-	0%	-	34,609,569	50%	12,340,117	18%	22,547,791	32%	69,497,477
1983	-	0%	1,000	100%	-	0%	1,000	35,047,727	46%	26,886,176	35%	14,117,970	19%	76,051,873
1984	85,000	54%	50,000	32%	22,750	14%	157,750	48,798,939	50%	24,645,736	25%	23,667,645	24%	97,112,320
1985	2,476,463	27%	4,722,203	51%	1,972,816	22%	9,171,482	44,572,316	49%	24,196,086	27%	21,812,702	24%	90,581,104
1986	23,553,734	46%	18,462,045	36%	8,997,916	18%	51,013,695	57,634,275	53%	31,609,161	29%	20,507,822	19%	109,751,258
1987	25,265,802	38%	17,881,804	27%	23,102,519	35%	66,170,125	53,992,059	42%	32,898,648	26%	40,270,072	32%	127,160,779
1988	22,473,678	47%	17,612,398	37%	7,729,262	16%	47,815,338	48,458,540	42%	43,389,535	38%	23,527,833	20%	115,275,908
1989	37,618,495	46%	29,889,588	36%	14,876,139	18%	82,384,222	51,057,379	40%	48,865,599	38%	28,507,256	22%	128,430,232
1990	26,120,582	32%	24,948,889	30%	31,299,282	38%	82,368,753	33,207,800	29%	44,267,843	39%	37,157,978	32%	114,633,621
1991	33,283,574	48%	18,391,513	26%	17,911,574	26%	69,586,661	53,614,885	37%	54,842,771	37%	38,077,277	26%	146,534,933
1992	36,464,888	44%	32,568,042	39%	13,345,480	16%	82,378,410	50,021,116	37%	46,447,843	35%	37,312,237	28%	133,781,196
1993	26,147,869	26%	39,498,867	40%	33,159,599	34%	98,806,335	39,087,417	31%	47,097,163	37%	39,660,607	32%	125,845,187
1994	34,513,134	37%	34,378,946	37%	23,573,152	25%	92,665,232	46,467,016	29%	56,375,149	35%	56,935,389	36%	159,777,554
1995	53,332,137	38%	35,596,527	40%	30,950,507	22%	139,879,171	55,334,462	27%	71,396,223	35%	79,718,514	39%	206,449,199
1996	63,155,962	38%	46,137,269	28%	57,524,731	34%	166,817,962	68,847,682	29%	85,407,043	36%	85,621,102	36%	239,875,827
1997	68,055,134	41%	58,343,133	35%	39,166,972	24%	165,565,239	69,382,869	34%	60,494,101	30%	72,873,654	36%	202,750,624
1998	39,745,640	31%	63,271,412	49%	26,643,063	21%	129,660,115	54,353,147	30%	63,405,742	35%	64,482,869	35%	182,241,758
1999	56,110,475	39%	53,896,170	37%	34,042,614	24%	144,049,259	72,881,833	33%	59,456,043	27%	88,628,622	40%	220,966,498
2000	49,188,116	42%	24,639,048	21%	42,362,429	36%	116,189,593	54,971,102	25%	79,003,982	35%	89,096,465	40%	223,149,549
2001	44,227,545	41%	28,571,316	27%	33,850,233	32%	106,649,114	48,656,457	24%	82,987,655	40%	74,033,185	36%	205,677,297
2002	8,945,722	27%	11,492,185	35%	12,099,206	37%	32,537,113	19,463,665	34%	15,839,853	27%	22,609,047	39%	57,912,565
Total	650,766,900	39%	580,472,355	34%	452,830,264	27%	1,684,069,519	1,097,643,110	35%	1,035,487,317	33%	1,004,091,845	32%	3,137,222,272

Florida Hospital Association
Historical Changes in Frequency of Medical Liability Claims
Total Florida
(Based on claim count data from the Florida Database and population information from the Census Bureau)

Attachment 5

Claim Close Year	(1)	(2)	(3) (1) / (2) * 100,000	(4) (3) / Prior (3)	(5)	(6)	(7) (5) / (6) * 100,000	(8) (7) / Prior (7)
	Hospital				Physician			
	Closed with Indemnity Payment	Florida Population	Frequency	% of Annual Increase in Frequency	Closed with Indemnity Payment	Florida Population	Frequency	% of Annual Increase in Frequency
(Blank)	-	-	-	-	-	-	-	-
1973	-	-	-	-	4	-	-	-
1974	-	-	-	-	15	-	-	-
1975	-	-	-	-	375	-	-	-
1976	1	-	-	-	347	-	-	-
1977	-	-	-	-	322	-	-	-
1978	1	-	-	-	288	-	-	-
1979	-	-	-	-	240	-	-	-
1980	-	-	-	-	273	-	-	-
1981	-	-	-	-	438	-	-	-
1982	-	-	-	-	569	-	-	-
1983	1	-	-	-	590	-	-	-
1984	5	-	-	-	634	-	-	-
1985	122	-	-	-	731	-	-	-
1986	402	-	-	-	832	-	-	-
1987	531	-	-	-	866	-	-	-
1988	437	-	-	-	811	-	-	-
1989	425	-	-	-	784	-	-	-
1990	439	13,033,307	3.368	-	664	13,033,307	5.095	0%
1991	394	13,369,798	2.947	-13%	771	13,369,798	5.767	13%
1992	376	13,650,553	2.754	-7%	657	13,650,553	4.813	-17%
1993	348	13,927,185	2.499	-9%	724	13,927,185	5.198	8%
1994	333	14,239,444	2.339	-6%	802	14,239,444	5.632	8%
1995	466	14,537,875	3.205	37%	942	14,537,875	6.480	15%
1996	560	14,853,360	3.770	18%	1,087	14,853,360	7.318	13%
1997	607	15,186,304	3.997	6%	955	15,186,304	6.289	-14%
1998	559	15,486,559	3.610	-10%	1,001	15,486,559	6.464	3%
1999	478	15,759,421	3.033	-16%	828	15,759,421	5.254	-19%
2000	436	15,982,378	2.728	-10%	891	15,982,378	5.575	6%
2001	418	-	-	-	882	-	-	-
2002	107	-	-	-	240	-	-	-
Trend All Yr				1.2%				1.5%

Florida Hospital Association
Historical Average Annual Increase in Paid Loss for Medical Liability Claims
Florida Territory 1 - Dade and Broward
(Based on data from the Florida Database)

Attachment 6c

Claim Close Year	(1)	(2)	(3) (1) / (2)	(4) (3) / Prior (3)	(5)	(6)	(7) (5) / (6)	(8) (7) / Prior (7)
	Hospital				Physician			
	Total Paid Loss	Closed with Indemnity Payment Claims	Average Paid Loss	% of Annual Increase in Average Paid Loss	Total Paid Loss	Closed with Indemnity Payment Claims	Average Paid Loss	% of Annual Increase in Average Paid Loss
(Blank)	-	-	0		-	-	0	
1973	-	-	0	0%	131,050	3	43,683	0%
1974	-	-	0	0%	4,939	3	1,646	-96%
1975	-	-	0	0%	4,698,033	158	29,734	1706%
1976	450	1	450	0%	3,518,064	138	25,493	-14%
1977	-	-	0	-100%	3,844,330	124	31,003	22%
1978	2,500	1	2,500	0%	6,482,755	131	49,487	60%
1979	-	-	0	-100%	6,113,050	104	58,779	19%
1980	-	-	0	0%	13,390,831	117	114,452	95%
1981	-	-	0	0%	18,999,803	194	97,937	-14%
1982	-	-	0	0%	34,609,569	260	133,114	36%
1983	-	-	0	0%	35,047,727	264	132,757	0%
1984	85,000	2	42,500	0%	48,798,939	285	171,224	29%
1985	2,476,463	39	63,499	49%	44,572,316	273	163,269	-5%
1986	23,553,734	155	151,960	139%	57,634,275	348	165,616	1%
1987	25,265,802	246	102,707	-32%	53,992,059	396	136,344	-18%
1988	22,473,678	168	133,772	30%	48,458,540	305	158,880	17%
1989	37,618,495	173	217,448	63%	51,057,379	320	159,554	0%
1990	26,120,582	181	144,313	-34%	33,207,800	204	162,783	2%
1991	33,283,574	152	218,971	52%	53,614,885	264	203,087	25%
1992	36,464,888	147	248,060	13%	50,021,116	222	225,320	11%
1993	26,147,869	123	212,584	-14%	39,087,417	214	182,651	-19%
1994	34,513,134	128	269,634	27%	46,467,016	216	215,125	18%
1995	53,332,137	178	299,619	11%	55,334,462	282	196,221	-9%
1996	63,155,962	204	309,588	3%	68,847,682	336	204,904	4%
1997	68,055,134	235	289,596	-6%	69,382,869	356	194,896	-5%
1998	39,745,640	206	192,940	-33%	54,353,147	291	186,781	-4%
1999	56,110,475	143	392,381	103%	72,881,833	247	295,068	58%
2000	49,188,116	116	424,035	8%	54,971,102	221	248,738	-16%
2001	44,227,545	135	327,611	-23%	48,656,457	223	218,190	-12%
2002	8,945,722	34	263,109	-20%	19,463,665	60	324,394	49%
Trend All Yr				-				9.6%
86 - 02				6.4%				3.7%
98 - 02				4.5%				8.4%

Florida Hospital Association
Historical Percentage of Florida Closed with Payment Claims by Territory
(Based on data from the Florida Database)

Attachment 6a

Claim Close Year	(1)	(2) (1) / (7)	(3)	(4) (3) / (7)	(5)	(6) (5) / (7)	(7) (1) + (3) + (5)	(8)	(9) (8) / (14)	(10)	(11) (10) / (14)	(12)	(13) (12) / (14)	(14) (8) + (10) + (12)
	Hospital							Physician						
	Dade and Broward		Palm Beach, Hillsborough Pinellas, Orange, Duval		Remainder of Florida		Total Closed With Payment Claims	Dade and Broward		Palm Beach, Hillsborough Pinellas, Orange, Duval		Remainder of Florida		Total Closed With Payment Claims
	#	% of Total	#	% of Total	#	% of Total		#	% of Total	#	% of Total	#	% of Total	
(Blank)	-	0%	-	0%	-	0%	-	-	0%	-	0%	-	0%	-
1973	-	0%	-	0%	-	0%	-	3	75%	1	25%	-	0%	4
1974	-	0%	-	0%	-	0%	-	3	20%	8	53%	4	27%	15
1975	-	0%	-	0%	-	0%	-	158	42%	140	37%	77	21%	375
1976	1	100%	-	0%	-	0%	1	138	40%	117	34%	92	27%	347
1977	-	0%	-	0%	-	0%	-	124	39%	109	34%	89	28%	322
1978	1	100%	-	0%	-	0%	1	131	45%	91	32%	66	23%	288
1979	-	0%	-	0%	-	0%	-	104	43%	73	30%	63	26%	240
1980	-	0%	-	0%	-	0%	-	117	43%	98	36%	58	21%	273
1981	-	0%	-	0%	-	0%	-	194	44%	134	31%	110	25%	438
1982	-	0%	-	0%	-	0%	-	260	46%	168	30%	141	25%	569
1983	-	0%	1	100%	-	0%	1	264	45%	179	30%	147	25%	590
1984	2	40%	1	20%	2	40%	5	285	45%	202	32%	147	23%	634
1985	39	32%	56	46%	27	22%	122	273	37%	213	29%	245	34%	731
1986	155	39%	122	30%	125	31%	402	348	42%	234	28%	250	30%	832
1987	246	46%	155	29%	130	24%	531	396	46%	253	29%	217	25%	866
1988	168	38%	155	35%	114	26%	437	305	38%	281	35%	225	28%	811
1989	173	41%	158	37%	94	22%	425	320	41%	247	32%	217	28%	784
1990	181	41%	147	33%	111	25%	439	204	31%	271	41%	189	28%	664
1991	152	39%	131	33%	111	28%	394	264	34%	286	37%	221	29%	771
1992	147	39%	122	32%	107	28%	376	222	34%	226	34%	209	32%	657
1993	123	35%	107	31%	118	34%	348	214	30%	248	34%	262	36%	724
1994	128	38%	110	33%	95	29%	333	216	27%	295	37%	291	36%	802
1995	178	38%	138	30%	150	32%	466	282	30%	301	32%	359	38%	942
1996	204	36%	160	29%	196	35%	560	336	31%	362	33%	389	36%	1,087
1997	235	39%	186	31%	186	31%	607	356	37%	293	31%	306	32%	955
1998	206	37%	176	31%	177	32%	559	291	29%	335	33%	375	37%	1,001
1999	143	30%	160	33%	175	37%	478	247	27%	271	30%	310	34%	905
2000	116	27%	179	41%	141	32%	436	221	25%	324	36%	346	39%	891
2001	135	32%	153	37%	130	31%	418	223	25%	308	35%	351	40%	882
2002	34	32%	33	31%	40	37%	107	60	25%	70	29%	110	46%	240
Total	2,767	37%	2,450	33%	2,229	30%	7,446	6,559	35%	6,138	33%	5,866	32%	18,563

Florida Hospital Association
Historical Average Annual Increase in Paid Expense for Medical Liability Claims
Florida Territory 1 - Dade and Broward
(Based on data from the Florida Database)

Attachment 6f

	(1)	(2)	(3) (1) / (2)	(4) (3) / Prior (3)	(5)	(6)	(7) (5) / (6)	(8) (7) / Prior (7)
	Hospital				Physician			
Claim Close Year	Total Paid Expense	Closed with Indemnity Payment Claims	Average Paid Expense	% of Annual Increase in Average Paid Expense	Total Paid Expense	Closed with Indemnity Payment Claims	Average Paid Expense	% of Annual Increase in Average Paid Expense
(Blank)	-	-	0		-	-	0	
1973	-	-	0	0%	17,563	3	5,854	0%
1974	-	-	0	0%	2,231	3	744	-87%
1975	-	-	0	0%	747,980	158	4,734	537%
1976	-	1	0	0%	886,555	138	6,424	36%
1977	-	-	0	0%	670,996	124	5,411	-16%
1978	375	1	375	0%	946,367	131	7,224	34%
1979	-	-	0	-100%	893,870	104	8,595	19%
1980	-	-	0	0%	1,388,910	117	11,871	38%
1981	-	-	0	0%	2,091,128	194	10,779	-9%
1982	-	-	0	0%	3,331,548	260	12,814	19%
1983	-	-	0	0%	3,078,718	264	11,662	-9%
1984	8,941	2	4,471	0%	3,939,220	285	13,822	19%
1985	285,131	39	7,311	64%	3,850,411	273	14,104	2%
1986	2,206,306	155	14,234	95%	5,899,703	348	16,953	20%
1987	3,812,156	246	15,497	9%	9,029,220	396	22,801	34%
1988	5,167,391	168	30,758	98%	8,155,201	305	26,738	17%
1989	4,524,362	173	26,152	-15%	10,641,028	320	33,253	24%
1990	3,891,840	181	21,502	-18%	8,475,025	204	41,544	25%
1991	5,337,380	152	35,114	63%	14,633,169	264	55,429	33%
1992	4,751,090	147	32,320	-8%	10,116,874	222	45,572	-18%
1993	3,920,399	123	31,873	-1%	8,743,235	214	40,856	-10%
1994	5,564,729	128	43,474	36%	10,201,336	216	47,228	16%
1995	7,074,466	178	39,744	-9%	13,229,024	282	46,911	-1%
1996	9,018,593	204	44,209	11%	14,010,936	336	41,699	-11%
1997	8,372,089	235	35,626	-19%	13,616,001	356	38,247	-8%
1998	6,933,328	206	33,657	-6%	10,012,579	291	34,407	-10%
1999	5,820,810	143	40,705	21%	11,710,086	247	47,409	38%
2000	4,426,311	116	38,158	-6%	10,034,785	221	45,406	-4%
2001	5,579,733	135	41,331	8%	9,297,005	223	41,691	-8%
2002	1,141,620	34	33,577	-19%	3,232,297	60	53,872	29%
Trend								
All Yr				-				10.7%
86-02				5.0%				4.1%
98-02				0.1%				8.0%

Florida Hospital Association
Historical Average Annual Increase in Paid Loss for Medical Liability Claims
Florida Territory 2 - Palm Beach, Hillsborough, Pinellas, Orange, Duval Counties
(Based on data from the Florida Database)

Attachment 6d

	(1)	(2)	(3) (1) / (2)	(4) (3) / Prior (3)	(5)	(6)	(7) (5) / (6)	(8) (7) / Prior (7)
	Hospital				Physician			
Claim Close Year	Total Paid Loss	Closed with Indemnity Payment Claims	Average Paid Loss	% of Annual Increase in Average Paid Loss	Total Paid Loss	Closed with Indemnity Payment Claims	Average Paid Loss	% of Annual Increase in Average Paid Loss
(Blank)	-	-	0		-	-	0	
1973	-	-	0	0%	1,000	1	1,000	0%
1974	-	-	0	0%	138,167	8	17,271	1627%
1975	-	-	0	0%	4,673,663	140	33,383	93%
1976	-	-	0	0%	2,502,908	117	21,392	-36%
1977	-	-	0	0%	4,444,102	109	40,772	91%
1978	-	-	0	0%	3,398,332	91	37,344	-8%
1979	-	-	0	0%	4,843,861	73	66,354	78%
1980	-	-	0	0%	12,265,551	98	125,159	89%
1981	-	-	0	0%	11,387,264	134	84,980	-32%
1982	-	-	0	0%	12,340,117	168	73,453	-14%
1983	1,000	1	1,000	0%	26,886,176	179	150,202	104%
1984	50,000	1	50,000	4900%	24,645,736	202	122,009	-19%
1985	4,722,203	56	84,325	69%	24,196,086	213	113,597	-7%
1986	18,462,045	122	151,328	79%	31,609,161	234	135,082	19%
1987	17,801,804	155	114,850	-24%	32,898,648	253	130,034	-4%
1988	17,612,398	155	113,628	-1%	43,289,535	281	154,055	18%
1989	29,889,588	158	189,175	66%	48,865,599	247	197,836	28%
1990	24,948,889	147	169,720	-10%	44,267,843	271	163,350	-17%
1991	18,391,513	131	140,393	-17%	54,842,771	286	191,758	17%
1992	32,568,042	122	266,951	90%	46,447,843	226	205,521	7%
1993	39,498,867	107	369,148	38%	47,097,163	248	189,908	-8%
1994	34,578,946	110	314,354	-15%	56,375,149	295	191,102	1%
1995	55,596,527	138	402,873	28%	71,396,223	301	237,197	24%
1996	46,137,269	160	288,358	-28%	85,407,043	362	235,931	-1%
1997	58,343,133	186	313,673	9%	60,494,101	293	206,465	-12%
1998	63,271,412	176	359,497	15%	63,405,742	335	189,271	-8%
1999	53,896,170	160	336,851	-6%	59,456,043	271	219,395	16%
2000	24,639,048	179	137,648	-59%	79,083,982	324	244,086	11%
2001	28,571,316	153	186,741	36%	82,987,655	308	269,440	10%
2002	11,492,185	33	348,248	86%	15,839,851	70	226,284	-16%
Trend								
All Yr				-				10.8%
86 - 02				5.0%				3.4%
98 - 02				-6.3%				5.8%

Florida Hospital Association
Historical Average Annual Increase in Paid Expense for Medical Liability Claims
Florida Territory 2 - Palm Beach, Hillsborough, Pinellas, Orange, Duval Counties
(Based on data from the Florida Database)

Attachment 6g

	(1)	(2)	(3) (1) / (2)	(4) (3) / Prior (3)	(5)	(6)	(7) (5) / (6)	(8) (7) / Prior (7)
	Hospital				Physician			
Claim Close Year	Total Paid Expense	Closed with Indemnity Payment Claims	Average Paid Expense	% of Annual Increase in Average Paid Expense	Total Paid Expense	Closed with Indemnity Payment Claims	Average Paid Expense	% of Annual Increase in Average Paid Expense
(Blank)	-	-	0		-	-	0	
1973	-	-	0	0%	50	1	50	0%
1974	-	-	0	0%	22,488	8	2,811	5522%
1975	-	-	0	0%	581,044	140	4,150	48%
1976	-	-	0	0%	446,245	117	3,814	-8%
1977	-	-	0	0%	722,599	109	6,629	74%
1978	-	-	0	0%	628,995	91	6,912	4%
1979	-	-	0	0%	738,648	73	10,118	46%
1980	-	-	0	0%	911,389	98	9,300	-8%
1981	-	-	0	0%	953,534	134	7,116	-23%
1982	-	-	0	0%	1,078,673	168	6,421	-10%
1983	-	1	0	0%	1,643,726	179	9,183	43%
1984	15,056	1	15,056	0%	2,617,236	202	12,957	41%
1985	372,981	56	6,660	-56%	2,628,794	213	12,342	-5%
1986	1,618,789	122	13,269	99%	3,826,249	234	16,351	32%
1987	2,164,417	155	13,964	5%	4,685,666	253	18,520	13%
1988	2,502,947	155	16,148	16%	5,583,972	281	19,872	7%
1989	3,336,843	158	21,119	31%	6,958,259	247	28,171	42%
1990	2,029,867	147	13,809	-35%	7,679,550	271	28,338	1%
1991	2,451,257	131	18,712	36%	9,944,719	286	34,772	23%
1992	2,701,230	122	22,141	18%	6,788,023	226	30,036	-14%
1993	3,753,139	107	35,076	58%	9,741,164	248	39,279	31%
1994	4,189,979	110	38,091	9%	8,830,557	295	29,934	-24%
1995	3,608,310	138	26,147	-31%	10,514,501	301	34,932	17%
1996	6,689,214	160	41,808	60%	12,067,564	362	33,336	-5%
1997	5,690,118	186	30,592	-27%	10,576,705	293	36,098	8%
1998	6,816,814	176	38,732	27%	15,483,932	335	46,221	28%
1999	5,284,798	160	33,030	-15%	9,840,874	271	36,313	-21%
2000	4,521,682	179	25,261	-24%	13,300,837	324	41,052	13%
2001	4,499,029	153	29,405	16%	10,290,364	308	33,410	-19%
2002	829,927	33	25,149	-14%	2,538,877	70	36,270	9%
Trend								
All Yr				-				12.8%
86-02				5.5%				4.6%
98-02				-9.3%				-5.5%

Florida Hospital Association
Historical Average Annual Increase in Paid Loss for Medical Liability Claims
Florida Territory 3 - Remainder of State
(Based on data from the Florida Database)

Attachment 6e

	(1)	(2)	(3) (1) / (2)	(4) (3) / Prior (3)	(5)	(6)	(7) (5) / (6)	(8) (7) / Prior (7)
	Hospital				Physician			
Claim Close Year	Total Paid Loss	Closed with Indemnity Payment Claims	Average Paid Loss	% of Annual Increase in Average Paid Loss	Total Paid Loss	Closed with Indemnity Payment Claims	Average Paid Loss	% of Annual Increase in Average Paid Loss
(Blank)	-	-	0		-	-	0	
1973	-	-	0	0%	-	-	0	0%
1974	-	-	0	0%	30,500	4	7,625	0%
1975	-	-	0	0%	1,556,714	77	20,217	165%
1976	-	-	0	0%	2,207,933	92	23,999	19%
1977	-	-	0	0%	3,736,244	89	41,980	75%
1978	-	-	0	0%	2,192,608	66	33,221	-21%
1979	-	-	0	0%	2,994,246	63	47,528	43%
1980	-	-	0	0%	2,374,053	58	40,932	-14%
1981	-	-	0	0%	7,835,512	110	71,232	74%
1982	-	-	0	0%	22,547,791	141	159,913	124%
1983	-	-	0	0%	14,117,970	147	96,041	-40%
1984	22,750	2	11,375	0%	23,667,643	147	161,004	68%
1985	1,972,816	27	73,067	542%	21,812,702	245	89,031	-45%
1986	8,997,916	125	71,983	-1%	20,507,822	250	82,031	-8%
1987	23,102,519	130	177,712	147%	40,270,072	217	185,576	126%
1988	7,729,262	114	67,801	-62%	23,527,833	225	104,568	-44%
1989	14,876,139	94	158,257	133%	28,507,254	217	131,370	26%
1990	31,299,282	111	281,976	78%	37,157,973	189	196,603	50%
1991	17,911,574	111	161,366	-43%	38,077,277	221	172,295	-12%
1992	13,545,480	107	126,593	-22%	37,312,237	209	178,527	4%
1993	33,159,599	118	281,014	122%	39,660,607	262	151,376	-15%
1994	23,573,152	95	248,138	-12%	56,935,389	291	195,654	29%
1995	30,950,507	150	206,337	-17%	79,718,514	359	222,057	13%
1996	57,524,731	196	293,494	42%	85,621,102	389	220,106	-1%
1997	39,166,972	186	210,575	-28%	72,873,654	306	238,149	8%
1998	26,643,063	177	150,526	-29%	64,482,869	375	171,954	-28%
1999	34,042,614	175	194,529	29%	88,628,622	310	285,899	66%
2000	42,362,429	141	300,443	54%	89,094,465	346	257,498	-10%
2001	33,850,253	130	260,387	-13%	74,033,185	351	210,921	-18%
2002	12,099,206	40	302,480	16%	22,609,047	110	205,537	-3%
Trend								
All Yr				-				-
86 - 02				6.0%				4.7%
98 - 02				18.4%				0.5%

Florida Hospital Association
Historical Changes in Frequency of Medical Liability Claims
Florida Territory 2 - Palm Beach, Hillsborough, Pinellas, Orange, Duval Counties
(Based on claim count data from the Florida Database and population information from the Census Bureau)

Attachment 6j

	(1)	(2)	(3) (1) / (2) * 100,000	(4) (3) / Prior (3)	(5)	(6)	(7) (5) / (6) * 100,000	(8) (7) / Prior (7)
	Hospital				Physician			
Claim Close Year	Closed with Indemnity Payment Claims	Population	Frequency	% of Annual Increase in Frequency	Closed with Indemnity Payment Claims	Population	Frequency	% of Annual Increase in Frequency
(Blank)	-	-	-	-	-	-	-	-
1973	-	-	-	-	1	-	-	-
1974	-	-	-	-	8	-	-	-
1975	-	-	-	-	140	-	-	-
1976	-	-	-	-	117	-	-	-
1977	-	-	-	-	109	-	-	-
1978	-	-	-	-	91	-	-	-
1979	-	-	-	-	73	-	-	-
1980	-	-	-	-	98	-	-	-
1981	-	-	-	-	134	-	-	-
1982	-	-	-	-	168	-	-	-
1983	1				179	-	-	-
1984	1				202	-	-	-
1985	56	3,586,807	1.561	0%	213	3,586,807	5.938	0%
1986	122	3,654,687	3.338	114%	234	3,654,687	6.403	8%
1987	155	3,723,852	4.162	25%	253	3,723,852	6.794	6%
1988	155	3,794,325	4.085	-2%	281	3,794,325	7.406	9%
1989	158	3,866,133	4.087	0%	247	3,866,133	6.389	-14%
1990	147	3,928,268	3.742	-8%	271	3,928,268	6.899	8%
1991	131	4,017,003	3.261	-13%	286	4,017,003	7.120	3%
1992	122	4,096,749	2.978	-9%	226	4,096,749	5.517	-23%
1993	107	4,170,667	2.566	-14%	248	4,170,667	5.946	8%
1994	110	4,245,207	2.591	1%	295	4,245,207	6.949	17%
1995	138	4,316,184	3.197	23%	301	4,316,184	6.974	0%
1996	160	4,404,196	3.633	14%	362	4,404,196	8.219	18%
1997	186	4,505,115	4.129	14%	293	4,505,115	6.504	-21%
1998	176	4,596,239	3.829	-7%	335	4,596,239	7.289	12%
1999	160	4,668,053	3.428	-10%	271	4,668,053	5.805	-20%
2000	179	4,726,837	3.787	10%	324	4,726,837	6.854	18%
2001	153	4,841,534	3.160	-17%	308	4,841,534	6.362	-7%
2002	33	4,933,159	0.669	-79%	70	4,933,159	1.419	-78%
Trend								
All Yr				-0.5%				0.0%
1998 - 2001				-4.7%				-2.4%

Florida Hospital Association
Historical Average Annual Increase in Paid Expense for Medical Liability Claims
Florida Territory 3 - Remainder of State
(Based on data from the Florida Database)

Attachment 6h

	(1)	(2)	(3) (1) / (2)	-400% (3) / Prior (3)	(5)	(6)	(7) (5) / (6)	-800% (7) / Prior (7)
	Hospital				Physician			
Claim Close Year	Total Paid Expense	Closed with Indemnity Payment Claims	Average Paid Expense	% of Annual Increase in Average Paid Expense	Total Paid Expense	Closed with Indemnity Payment Claims	Average Paid Expense	% of Annual Increase in Average Paid Expense
(Blank)	-	-	-		-	-	-	
1973	-	-	-	0%	-	-	-	0%
1974	-	-	-	0%	760	4	190	0%
1975	-	-	-	0%	233,418	77	3,031	1495%
1976	-	-	-	0%	430,075	92	4,675	54%
1977	-	-	-	0%	603,004	89	6,775	45%
1978	-	-	-	0%	409,770	66	6,209	-8%
1979	-	-	-	0%	458,212	63	7,273	17%
1980	-	-	-	0%	393,363	58	6,782	-7%
1981	-	-	-	0%	899,829	110	8,180	21%
1982	-	-	-	0%	1,606,309	141	11,392	39%
1983	-	-	-	0%	1,455,866	147	9,904	-13%
1984	3,591	2	1,796	0%	2,191,780	147	14,910	51%
1985	451,380	27	16,718	831%	2,763,807	245	11,281	-24%
1986	811,746	125	6,494	-61%	3,627,685	250	14,511	29%
1987	1,876,959	130	14,438	122%	3,741,717	217	17,243	19%
1988	1,007,489	114	8,838	-39%	3,856,927	225	17,142	-1%
1989	1,450,444	94	15,430	75%	5,504,478	217	25,366	48%
1990	2,487,724	111	22,412	45%	7,183,759	189	38,009	50%
1991	1,999,625	111	18,015	-20%	7,624,152	221	34,498	-9%
1992	1,965,762	107	18,372	2%	6,303,257	209	30,159	-13%
1993	4,096,536	118	34,716	89%	8,618,749	262	32,896	9%
1994	2,324,561	95	24,469	-30%	9,351,712	291	32,136	-2%
1995	4,327,318	150	28,849	18%	12,209,771	359	34,011	6%
1996	4,329,814	196	22,091	-23%	11,906,142	389	30,607	-10%
1997	5,579,910	186	30,000	36%	8,740,300	306	28,563	-7%
1998	4,535,363	177	25,624	-15%	10,536,850	375	28,098	-2%
1999	3,981,953	175	22,754	-11%	12,144,309	310	39,175	39%
2000	4,442,217	141	31,505	38%	14,026,833	346	40,540	3%
2001	4,361,001	130	33,546	6%	12,451,632	351	35,475	-12%
2002	1,149,870	40	28,747	-14%	3,999,396	110	36,358	2%
Trend								
All Yr								
86-02				8%				5%
98-02				6%				4%

Florida Hospital Association
Historical Changes in Frequency of Medical Liability Claims
Florida Territory 3 - Remainder of State
(Based on claim count data from the Florida Database and population information from the Census Bureau)

Attachment 6k

	(1)	(2)	(3) (1) / (2) * 100,000	(4) (3) / Prior (3)	(5)	(6)	(7) (5) / (6) * 100,000	(8) (7) / Prior (7)
	Hospital				Physician			
Claim Close Year	Closed with Indemnity Payment Claims	Population	Frequency	% of Annual Increase in Frequency	Closed with Indemnity Payment Claims	Population	Frequency	% of Annual Increase in Frequency
(Blank)	-	-	-	-	-	-	-	-
1973	-	-	-	-	-	-	-	-
1974	-	-	-	-	4	-	-	-
1975	-	-	-	-	77	-	-	-
1976	-	-	-	-	92	-	-	-
1977	-	-	-	-	89	-	-	-
1978	-	-	-	-	66	-	-	-
1979	-	-	-	-	63	-	-	-
1980	-	-	-	-	58	-	-	-
1981	-	-	-	-	110	-	-	-
1982	-	-	-	-	141	-	-	-
1983	-	-	-	-	147	-	-	-
1984	2	-	-	-	147	-	-	-
1985	27	5,307,805	0.509	0%	245	5,307,805	4.616	0%
1986	125	5,429,512	2.302	353%	250	5,429,512	4.604	0%
1987	130	5,554,010	2.341	2%	217	5,554,010	3.907	-15%
1988	114	5,681,362	2.007	-14%	225	5,681,362	3.960	1%
1989	94	5,811,635	1.617	-19%	217	5,811,635	3.734	-6%
1990	111	5,898,021	1.882	16%	189	5,898,021	3.204	-14%
1991	111	6,074,916	1.827	-3%	221	6,074,916	3.638	14%
1992	107	6,217,255	1.721	-6%	209	6,217,255	3.362	-8%
1993	118	6,373,357	1.851	8%	262	6,373,357	4.111	22%
1994	95	6,537,084	1.453	-22%	291	6,537,084	4.452	8%
1995	150	6,688,281	2.243	54%	359	6,688,281	5.368	21%
1996	196	6,836,894	2.867	28%	389	6,836,894	5.690	6%
1997	186	7,000,658	2.657	-7%	306	7,000,658	4.371	-23%
1998	177	7,149,590	2.476	-7%	375	7,149,590	5.245	20%
1999	175	7,276,277	2.405	-3%	310	7,276,277	4.260	-19%
2000	141	7,379,161	1.911	-21%	346	7,379,161	4.689	10%
2001	130	7,628,663	1.704	-11%	351	7,628,663	4.601	-2%
2002	40	7,803,587	0.513	-70%	110	7,803,587	1.410	-69%
Trend								
All Yr				0.6%				1.8%
1998 - 2001				-12.6%				-2.9%

Florida Hospital Association
Historical Changes in Frequency of Medical Liability Claims
Florida Territory 1 - Dade and Broward
(Based on claim count data from the Florida Database and population information from the Census Bureau)

Attachment 6i

	(1)	(2)	(3) (1) / (2) * 100,000	(4) (3) / Prior (3)	(5)	(6)	(7) (5) / (6) * 100,000	(8) (7) / Prior (7)
	Hospital				Physician			
Claim Close Year	Closed with Indemnity Payment Claims	Population	Frequency	% of Annual Increase in Frequency	Closed with Indemnity Payment Claims	Population	Frequency	% of Annual Increase in Frequency
(Blank)	-	-	-	-	-	-	-	-
1973	-	-	-	-	3	-	-	-
1974	-	-	-	-	3	-	-	-
1975	-	-	-	-	158	-	-	-
1976	1	-	-	-	138	-	-	-
1977	-	-	-	-	124	-	-	-
1978	1	-	-	-	131	-	-	-
1979	-	-	-	-	104	-	-	-
1980	-	-	-	-	117	-	-	-
1981	-	-	-	-	194	-	-	-
1982	-	-	-	-	260	-	-	-
1983	-	-	-	-	264	-	-	-
1984	2	-	-	-	285	-	-	-
1985	39	2,915,180	1.338		273	2,915,180	9.365	
1986	155	2,971,646	5.216	290%	348	2,971,646	11.711	25%
1987	246	3,029,206	8.121	56%	396	3,029,206	13.073	12%
1988	168	3,087,880	5.441	-33%	305	3,087,880	9.877	-24%
1989	173	3,147,691	5.496	1%	320	3,147,691	10.166	3%
1990	181	3,207,018	5.644	3%	204	3,207,018	6.361	-37%
1991	152	3,277,879	4.637	-18%	264	3,277,879	8.054	27%
1992	147	3,336,549	4.406	-5%	222	3,336,549	6.654	-17%
1993	123	3,383,161	3.636	-17%	214	3,383,161	6.325	-5%
1994	128	3,457,153	3.702	2%	216	3,457,153	6.248	-1%
1995	178	3,533,410	5.038	36%	282	3,533,410	7.981	28%
1996	204	3,612,270	5.647	12%	336	3,612,270	9.302	17%
1997	235	3,680,531	6.385	13%	356	3,680,531	9.673	4%
1998	206	3,740,730	5.507	-14%	291	3,740,730	7.779	-20%
1999	143	3,815,091	3.748	-32%	247	3,815,091	6.474	-17%
2000	116	3,876,380	2.992	-20%	221	3,876,380	5.701	-12%
2001	135	3,962,529	3.407	14%	223	3,962,529	5.628	-1%
2002	34	4,039,282	0.842	-75%	60	4,039,282	1.485	-74%
Trend								
All Yr				-3.1%				-3.6%
1998 - 2001				-15.3%				-10.4%

Florida Hospital Association
NPDB Loss Data for Largest States and Nationwide
NPDB Public Use Data File

9/1/90-4/30/01

Total Claims (#) and Losses ($) reported to the NPDB

	Claims	Losses	Average Cost (Severity)	Relativity
CA	16,918	2,061,706,650	121,865	0.60
FL	9,819	2,114,508,250	215,349	1.06
IL	6,844	2,162,800,350	316,014	1.56
MA	2,844	814,925,350	286,542	1.41
MI	8,625	856,415,200	99,295	0.49
NJ	6,108	1,447,981,550	237,063	1.17
NY	20,208	5,168,962,250	255,788	1.26
OH	7,129	1,540,057,650	216,027	1.06
PA	13,648	2,982,956,900	218,564	1.08
TX	10,781	1,882,374,850	174,601	0.86
All Others	52,435	10,516,962,100	200,571	0.99
Total	155,359	31,549,651,100	203,076	

National Claim and Loss Rate per Person Reported to the NPDB
(annual losses not trended)

	Population (1990)	Annual Claim Rate per 100,000 (Patient Frequency)	Relativity	Annual Loss per Person (Patient Pure Premium)	Relativity
CA	29,760,021	5.33	0.91	6.49	0.55
FL	12,937,926	7.11	1.21	15.32	1.29
IL	11,430,602	5.61	0.96	17.73	1.49
MA	6,016,425	4.43	0.76	12.69	1.07
MI	9,295,297	8.70	1.49	8.63	0.73
NJ	7,730,188	7.41	1.26	17.56	1.48
NY	17,990,455	10.53	1.80	26.93	2.26
OH	10,847,115	6.16	1.05	13.31	1.12
PA	11,881,643	10.77	1.84	23.53	1.98
TX	16,986,510	5.95	1.02	10.39	0.87
All Others	113,833,691	4.32	0.74	8.66	0.73
Total	248,709,873	5.85		11.89	

National Claim and Loss Rate per Doctor Reported to the NPDB
(annual losses not trended)

	Doctors (approximate number in 1990)	Annual Claim Rate per 100 Doctors (Doctor Frequency)	Relativity	Annual Loss Per Doctor (doctor pure premium)	Relativity
CA	70,829	2.24	0.82	2,728	0.49
FL	26,393	3.49	1.28	7,509	1.36
IL	24,804	2.59	0.95	8,172	1.48
MA	19,975	1.33	0.49	3,824	0.69
MI	17,103	4.73	1.74	4,693	0.85
NJ	19,016	3.01	1.11	7,136	1.29
NY	56,490	3.35	1.23	8,576	1.56
OH	21,369	3.13	1.15	6,754	1.22
PA	28,278	4.52	1.67	9,886	1.79
TX	29,726	3.40	1.25	5,935	1.08
All Others	222,265	2.21	0.81	4,435	0.80
Total	536,250	2.72		5,514	

2000 Only

Total Claims (#) and Losses ($) reported to the NPDB

	Claims	Losses	Average Cost (Severity)	Relativity
CA	1,397	195,558,150	139,984	0.57
FL	1,209	306,424,550	253,453	1.03
IL	590	268,871,000	455,714	1.85
MA	323	124,112,500	384,249	1.56
MI	672	77,788,100	115,756	0.47
NJ	610	191,405,250	313,779	1.27
NY	2,137	636,290,500	297,749	1.21
OH	850	204,865,750	241,019	0.98
PA	1,410	350,618,050	248,665	1.01
TX	1,115	210,589,350	188,869	0.77
All Others	5,289	1,281,173,700	242,234	0.98
Total	15,602	3,847,696,900	246,616	

National Claim and Loss Rate per Person Reported to the NPDB
(annual losses not trended)

	Population (1995)	Annual Claim Rate per 100,000 (Patient Frequency)	Relativity	Annual Loss per Person (Patient Pure Premium)	Relativity
CA	31,696,582	4.41	0.75	6.17	0.43
FL	14,537,875	8.32	1.42	21.08	1.46
IL	12,008,437	4.91	0.84	22.39	1.55
MA	6,141,445	5.26	0.90	20.21	1.40
MI	9,676,211	6.94	1.19	8.04	0.56
NJ	8,083,242	7.55	1.29	23.68	1.64
NY	18,524,104	11.54	1.97	34.35	2.38
OH	11,202,751	7.59	1.29	18.29	1.27
PA	12,198,403	11.56	1.97	28.74	1.99
TX	18,958,751	5.88	1.00	11.11	0.77
All Others	123,250,592	4.29	0.73	10.39	0.72
Total	266,278,393	5.86		14.45	

National Claim and Loss Rate per Doctor Reported to the NPDB
(annual losses not trended)

	Doctors (approximate number in 1995)	Annual Claim Rate per 100 Doctors (Doctor Frequency)	Relativity	Annual Loss Per Doctor (doctor pure premium)	Relativity
CA	75,112	1.86	0.74	2,604	0.42
FL	32,059	3.77	1.51	9,558	1.55
IL	28,964	2.04	0.81	9,283	1.51
MA	23,215	1.39	0.56	5,346	0.87
MI	20,512	3.28	1.31	3,792	0.62
NJ	21,792	2.80	1.12	8,783	1.42
NY	64,506	3.31	1.32	9,864	1.60
OH	24,745	3.44	1.37	8,279	1.34
PA	32,724	4.31	1.72	10,714	1.74
TX	35,282	3.16	1.26	5,989	0.97
All Others	265,101	2.00	0.80	4,833	0.78
Total	624,011	2.50		6,166	

Florida Hospital Association
Number of Cases
NPDB Public Use Data File - 4/30/01

Florida Hospital Association
Paid Losses
NPDB Public Use Data File - 4/30/01

Florida Hospital Association
Average Per Case Loss (Severity)
NPDB Public Use Data File - 4/30/01

Florida Hospital Association
NPDB 2000 Claim, Loss, and Doctor Population Data for All States
NPDB Public Use Data File

	Doctors (approximate number in 1995)	Claims Closed in 2000	Annual Claim Rate per 100 Doctors (Doctor Frequency)	Frequency Rank	Losses Paid in 2000	Annual Loss Per Doctor (doctor pure premium)	Pure Premium Rank	Average Paid Loss in 2000 (Severity)	Severity Rank
Alabama	8,092	84	1.04	49	32,750,850	4,047	38	389,891	4
Alaska	906	17	1.88	32	3,210,000	3,543	41	188,824	43
Arizona	8,517	264	3.10	12	68,270,000	8,016	12	258,598	18
Arkansas	4,442	67	1.51	40	14,850,800	3,343	45	221,654	35
California	75,112	1,397	1.86	33	195,558,150	2,604	48	139,984	50
Colorado	8,332	142	1.70	37	34,631,500	4,156	33	243,884	27
Connecticut	10,659	166	1.56	38	71,477,000	6,706	14	430,584	3
Delaware	1,591	30	1.89	31	9,469,750	5,952	22	315,658	9
District of Columbia	3,526	63	1.79	34	37,302,000	10,580	4	592,095	1
Florida	32,059	1,209	3.77	5	306,424,550	9,558	7	253,453	20
Georgia	14,259	274	1.92	29	90,133,300	6,321	17	328,954	7
Hawaii	2,848	40	1.40	43	10,015,000	3,516	42	250,375	21
Idaho	1,703	33	1.94	28	8,450,750	4,962	29	256,083	19
Illinois	28,964	590	2.04	27	268,871,000	9,283	8	455,714	2
Indiana	10,746	292	2.72	17	59,934,800	5,577	25	205,256	39
Iowa	4,769	121	2.54	21	26,611,750	5,581	24	219,932	36
Kansas	5,079	190	3.74	6	28,812,050	5,673	23	151,642	48
Kentucky	7,674	190	2.48	22	33,176,750	4,323	31	174,625	46
Louisiana	9,847	297	3.02	14	50,289,000	5,107	28	169,323	47
Maine	2,433	66	2.71	18	18,849,500	7,748	13	285,598	14
Maryland	17,455	248	1.42	42	67,373,750	3,860	39	271,668	16
Massachusetts	23,215	323	1.39	45	124,112,500	5,346	26	384,249	5
Michigan	20,512	672	3.28	10	77,788,100	3,792	40	115,756	51
Minnesota	11,059	89	0.80	50	19,994,750	1,808	51	224,660	34
Mississippi	4,055	116	2.86	15	24,259,550	5,983	19	209,134	37
Missouri	11,706	201	1.72	36	48,402,000	4,135	35	240,806	30
Montana	1,628	67	4.12	4	15,590,250	9,577	6	232,690	32
Nebraska	3,393	78	2.30	25	13,948,550	4,111	36	178,828	44
Nevada	2,508	115	4.58	1	36,309,000	14,475	1	315,730	8
New Hampshire	2,597	69	2.66	20	17,087,000	6,580	15	247,638	25
New Jersey	21,792	610	2.80	16	191,405,250	8,783	9	313,779	10
New Mexico	3,484	108	3.10	13	20,745,500	5,954	21	192,088	41
New York	64,506	2,137	3.31	9	636,290,500	9,864	5	297,749	12
North Carolina	15,366	214	1.39	44	65,866,000	4,287	32	307,785	11
North Dakota	1,385	19	1.37	46	4,672,750	3,374	44	245,934	26
Ohio	24,745	850	3.44	7	204,865,750	8,279	10	241,019	29
Oklahoma	5,445	103	1.89	30	28,217,250	5,182	27	273,954	15
Oregon	6,817	83	1.22	48	23,877,500	3,503	43	287,681	13
Pennsylvania	32,724	1,410	4.31	3	350,618,050	10,714	3	248,665	23
Rhode Island	3,061	71	2.32	24	18,792,300	6,139	18	264,680	17
South Carolina	6,986	163	2.33	23	28,947,000	4,144	34	177,589	45
South Dakota	1,244	27	2.17	26	5,547,500	4,460	30	205,463	38
Tennessee	12,390	177	1.43	41	35,048,500	2,829	47	198,014	40
Texas	35,282	1,115	3.16	11	210,589,350	5,969	20	188,869	42
Utah	3,827	103	2.69	19	24,841,250	6,491	16	241,177	28
Vermont	1,557	24	1.54	39	3,416,750	2,194	50	142,365	49
Virginia	14,809	201	1.36	47	45,658,500	3,083	46	227,157	33
Washington	12,181	212	1.74	35	49,444,500	4,059	37	233,229	31
West Virginia	3,662	166	4.53	2	41,462,250	11,321	2	249,773	22
Wisconsin	11,109	76	0.68	51	26,982,750	2,429	49	355,036	6
Wyoming	780	26	3.33	8	6,449,000	8,265	11	248,038	24
United States	624,011	15,602	2.50		3,847,696,900	6,166		246,616	

Notes

...ical Abstract of the United StatesActive Non-Federal Physicians by State
... Public Use Data File
...umber of Doctors
... of Doctors

Florida Hospital Association
Historical Number and Cost of Malpractice Cases in Emergency Rooms and Other Event Location
Total Florida
(Based on data from the Florida Database)

Number of Claims

Claim Closed Year	Hospital Inpatient	Emergency Room	Physician's Office/Home	Hospital Outpatient	Nursing Home	Patient's Home	Other Outpatient	Other Location	Other Hospital / Institution	No Response	Total
1986	826	105	195	28	2	6	21	20	8	23	1,211
1987	906	164	197	44	4	11	13	26	4	28	1,369
1988	820	105	202	37	3	22	21	21	6	11	1,237
1989	777	95	223	42	4	21	18	21	3	5	1,204
1990	706	112	187	41	5	8	20	16	3	6	1,097
1991	746	105	216	42	5	11	24	12	1	3	1,162
1992	801	109	203	58	1	12	19	21	6	3	1,030
1993	617	124	236	39	5	8	19	18	3	3	1,069
1994	635	149	249	39	2	14	15	20	6	6	1,129
1995	818	172	260	56	8	13	32	35	7	7	1,401
1996	1,052	136	278	62	16	21	38	31	7	6	1,641
1997	940	190	255	64	4	24	47	28	6	6	1,556
1998	856	187	310	72	10	31	52	26	7	9	1,551
1999	741	139	191	67	5	31	51	65	14	2	1,304
2000	771	114	202	66	15	32	50	68	9		1,327
2001	698	129	162	63	14	19	72	108	35		1,300
2002	173	40	53	15	3	2	23	26	12		347

Paid Loss ($)

Claim Closed Year	Hospital Inpatient	Emergency Room	Physician's Office/Home	Hospital Outpatient	Nursing Home	Patient's Home	Other Outpatient	Other Location	Other Hospital / Institution	No Response	Total
1986	120,338,208	10,118,814	21,183,020	1,341,912	202,500	1,080,250	1,004,847	1,638,531	937,566	2,919,507	157,845,446
1987	134,961,818	27,091,669	18,153,525	3,889,762	43,000	823,315	220,171	4,092,671	130,500	3,924,473	189,406,431
1988	115,178,521	6,759,715	22,285,264	7,504,364	114,142	6,242,055	814,449	2,717,612	459,022	1,016,102	162,075,144
1989	152,357,243	12,113,291	35,868,079	2,494,117	56,166	4,495,347	1,648,545	1,211,804	125,000	444,862	210,369,592
1990	140,067,089	17,800,246	28,784,725	3,051,088	257,500	679,000	3,205,773	1,939,453	252,500	965,000	196,037,374
1991	151,867,545	23,048,414	27,706,295	7,863,975	355,000	1,044,035	2,524,500	1,626,786	15,000	50,044	216,071,550
1992	133,354,719	22,300,284	41,496,894	6,214,454	1,000	5,065,799	3,786,801	1,527,790	2,544,765	67,500	216,292,106
1993	142,747,614	33,097,458	34,577,023	3,717,122	619,998	2,751,157	4,377,849	1,803,300	565,000	395,000	224,256,522
1994	148,216,147	40,336,111	43,732,928	6,042,545	205,000	2,508,331	1,557,400	7,776,592	1,648,059	421,673	252,021,113
1995	234,469,915	36,030,074	43,335,955	9,791,526	572,500	3,639,000	7,489,825	6,861,825	2,852,750	1,285,000	345,043,370
1996	284,518,469	26,377,375	54,153,196	12,760,709	2,096,573	9,079,000	8,030,164	6,782,463	453,840	2,442,000	404,251,789
1997	245,728,264	44,604,491	50,025,150	8,911,939	362,500	2,811,500	8,342,296	4,997,193	1,679,000	853,530	367,462,333
1998	178,911,850	30,228,024	58,889,087	14,144,229	1,342,400	4,622,501	8,842,824	8,435,375	480,833	5,004,750	306,897,123
1999	242,315,083	25,555,894	42,181,374	9,307,852	460,000	7,710,243	10,615,508	23,689,023	2,306,000	875,000	364,140,757
2000	203,464,666	27,596,934	43,540,793	17,053,203	1,950,000	8,935,000	12,094,050	21,937,839	2,788,657		339,339,142
2001	169,722,737	49,587,959	34,454,824	9,623,822	1,892,500	3,310,000	16,022,766	23,427,221	4,274,582		312,326,411
2002	48,085,229	13,857,500	8,534,081	4,174,500	630,000	260,000	4,811,000	7,412,368	2,685,000		90,449,678

Severity (Cost Per Claim)

Claim Closed Year	Hospital Inpatient	Emergency Room	Physician's Office/Home	Hospital Outpatient	Nursing Home	Patient's Home	Other Outpatient	Other Location	Other Hospital / Institution	No Response	Total
1986	145,688	96,368	108,631	47,925	101,250	180,042	47,850	81,927	117,196	126,935	130,343
1987	148,964	165,193	92,150	88,404	10,750	74,847	16,936	157,410	32,625	140,160	138,354
1988	140,462	64,378	110,323	202,821	38,047	283,730	38,783	129,410	76,504	92,373	131,023
1989	196,084	127,508	160,843	59,384	14,042	214,064	91,586	57,705	41,667	88,972	174,726
1990	198,677	158,931	153,929	74,417	51,500	84,875	160,289	121,216	84,167	160,833	178,703
1991	203,576	219,500	128,270	187,714	71,000	94,912	105,188	135,566	15,000	16,681	185,948
1992	221,888	204,590	204,417	107,146	1,000	422,150	199,295	72,752	424,128	22,500	209,992
1993	231,358	266,915	146,513	95,311	124,000	343,895	230,413	100,183	188,333	131,667	209,782
1994	233,411	270,712	175,634	154,937	102,500	179,024	103,827	388,830	274,677	70,279	223,225
1995	286,638	209,477	166,677	174,849	71,563	279,923	234,057	196,052	407,536	183,571	246,284
1996	270,455	193,951	194,796	205,818	131,036	432,333	211,320	218,789	64,834	407,000	246,345
1997	261,413	234,760	196,177	139,249	90,625	117,146	177,496	192,200	279,833	142,255	236,158
1998	209,009	161,647	193,191	196,448	134,240	149,113	170,054	324,438	68,690	556,083	197,870
1999	327,011	183,855	220,845	138,920	92,000	248,718	208,147	364,447	164,714	437,500	279,249
2000	263,897	242,078	215,548	258,382	130,000	279,219	241,881	322,615	307,406	-	255,719
2001	243,156	384,480	212,684	152,759	135,179	174,211	222,538	216,919	122,131	-	240,251
2002	277,949	346,438	161,020	278,300	210,000	130,000	209,174	285,091	223,750	-	260,682

Roddenberry

THE FLORIDA SENATE

COMMITTEE ON JUDICIARY

Location
515 Knott Building
Mailing Address
404 South Monroe Street
Tallahassee, Florida 32399-1100
(850) 487-5198
J. Alex Villalobos, *Chair*
Dave Aronberg, *Vice Chair*
Dawn Roberts, *Staff Director*
Senate's Website: *www.flsenate.gov*

July 29, 2003

Steven Roddenberry
Deputy Director, Florida Department of Insurance
Office of Insurance Regulation
200 E. Gaines Street
Tallahassee, Florida 32399-0326

Dear Mr. Roddenberry:

In reviewing the transcript of the Senate Committee on Judiciary meeting on July 14-15, 2003, we have identified several occurrences where you were asked to provide information subsequent to your testimony. Additionally, the committee has identified certain issues for which it requests additional information. Specifically, we request a response in the following instances:

1. Regarding Reserves:

   a. What has to happen to trigger a claim being "opened" by an insurer and a reserve being set? Is there a uniform definition or criteria that is used in the industry? Do Florida carriers apply this definition or criteria?

   b. Is a claim opened and are monies reserved in each of the following circumstances:

      i. An insured physician calls the insurer to alert the insurer that a patient is unhappy with a medical outcome and has threatened to sue.

      ii. An insured physician calls his insurer to report a medical error he had made.

      iii. The physician calls the insurer to report that he has received a notice of intent to litigate.

   c. You indicated in your testimony that the reserves are reviewed on a per-claim basis and reconciled to the reserves reported pursuant to the financial statements, on Schedule P. you indicated that the numbers reported in the financial statements are in the aggregate and do not reflect the actual number of claims reserved for or the amount of the reserve set for each claim. Please provide Office of Insurance Regulation reserve reconciliations for the two largest carriers in Florida, as demonstrated by those carriers market share percentage, for each of the last 5 years.

   d. What are the criteria for reserves being set on claims incurred but not reported (IBNR)?

   e. How much have the largest 5 carriers in Florida, as demonstrated by those carriers market share percentage, reserved for IBNR over the last 5 years? As a percentage of the carrier's total reserves?

DEPARTMENT OF FINANCIAL SERVICES
OFFICE OF INSURANCE REGULATION

KEVIN M. MCCARTY
DIRECTOR

FINANCIAL SERVICES COMMISSION
JEB BUSH
GOVERNOR
TOM GALLAGHER
CHIEF FINANCIAL OFFICER
CHARLIE CRIST
ATTORNEY GENERAL
CHARLES BRONSON
COMMISSIONER OF AGRICULTURE

August 4, 2003

Honorable J. Alex Villalobos
Room 305 Senate Office Building
404 South Monroe Street
Tallahassee, FL 32399-1100

Dear Senator Villalobos:

Your letter dated July 29, 2003, was received, via Federal Express, on July 31, 2003. The Office of Insurance Regulation (Office) intends to respond to each question. Some of the answers, however, are included, at least in part, in a letter sent to your office on July 31, 2003. The answers to some of the questions in your recent letter may not be readily available as they regard the unique practices of insurers. The standards for many of these practices are not established in the Insurance Code.

The following responses are in the order of the questions initially posed.

1. Regarding Reserves:

a. The criterion for when a claim should be opened is not established in the Insurance Code. Companies may use criterion that is consistent with how they recognize and ultimately adjudicate claims. However, most insurers will recognize and open a claim when a demand by an individual or corporation is received to recover under a policy of insurance a loss which may come within that policy. Section 766.106(2), Florida Statutes, addresses some of the procedures that a person must follow prior to filing a medical malpractice claim. Under Chapter 4-166.021(8), Florida Administrative Code, "Notification of a claim" is defined as any notice to an insurer or its agent by a claimant or an insured that reasonably apprises the insurer that a loss has occurred. Pursuant to Subsection (9) of this same Chapter, "Notice of loss" means: a written notice, such as claim forms, medical bills, medical authorizations or other reasonable evidence of the claim that is ordinarily required of a claimant; or any notice by or on behalf of a claimant that reasonably apprises the insurer that a loss has occurred and that the claimant wishes to make a claim under an insurance policy or against a person insured under an insurance policy for such loss. Section 766.106(3), Florida Statutes,

J. STEVE RODDENBERRY • DEPUTY DIRECTOR • OFFICE OF INSURANCE REGULATION
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establishes the responsibility of the insurer in its timely review of the medical malpractice claim.

b. i-iii. The response to each of these scenarios may be different for each insurer. The Insurance Code does not specify the circumstances under which a claim may be opened and a reserve established thereon. However, in light of the guidance provided in the above mentioned statutes and rules, it is extremely likely that a claim will be opened in scenarios 1.b.i and 1.b.iii, referenced in your letter.

c. On page 14, line 7, the transcript reports my use of the word "triangle". While phonetically similar, the word that I actually used was *triennial*. I would like to elaborate further on my testimony. The triennial financial examinations of our domestic insurers will include a reserve analysis. The Office requests that the companies being examined provide individual claims information. Once this information is received from the company, the Office's actuarial staff will extrapolate the data and summarize the information into accident years, which is consistent with the Schedule P format as established in the National Association of Insurance Commissioners (NAIC) annual financial statement. It is then necessary to make sure this summarized data reconciles with that which is actually stated in the annual financial statement. If the data does not appear to reconcile, then further detail must be provided by the company to establish where the differences lie. Additionally, the company's opining actuary is required to reconcile the data he/she uses for their actuarial analysis in and to Schedule P. This is a requirement which is stated in the development of their actuarial opinion. Since this information is requested every three years, the data will not be available for the five year period as requested. Attached as Exhibit I is a copy of the Financial Examination of ProNational Insurance Company by its domestic regulator, the State of Michigan. The independent actuary hired by the examination team concludes, among other things, that the Company's reserves make a reasonable provision for all unpaid loss and loss expense obligations of the Company under the terms of its policies and agreements. Also included as Exhibit I is a copy of the Office's reconciliation of the reserving data for First Professionals Insurance Company (FPIC). This document summarizes the Office's analysis of the raw claim data provided by FPIC. In a sealed envelope accompanying this response is the actual raw claim data. This particular information is confidential pursuant to Section 624.319(3)(b), Florida Statutes, and exempt from Section 119.07(1), Florida Statutes. It is provided pursuant to an exemption in Section 624.319(3)(b), Florida Statutes, which states in pertinent part, "Such confidential and exempt information may be disclosed to another governmental entity, if disclosure is necessary for the receiving entity to perform its duties and responsibilities . . . . The receiving governmental entity or the association must maintain the confidential and exempt status of the information."

d. The criterion for setting reserves on IBNR claims is not established in the Insurance Code. Each insurer establishes this criterion. For the most part, medical malpractice carriers sell claims-made policies. By their nature, claims-made policies do not necessitate much in the way of incurred but not reported (IBNR) reserves. For all other lines of insurance, there are various techniques used to estimate the IBNR reserve. Attached are examples of some of the methods that are accepted by the Casualty Actuarial Society. These are only a selected number of techniques and other methods are available. When estimating the IBNR reserve, the opining actuary must use judgment to determine which method is appropriate. Please see Exhibit II.

e. As noted above, claims-made policies do not typically warrant a large volume of IBNR reserves. The National Association of Insurance Commissioners (NAIC), of which Office is a member, has developed a format for reporting the financial condition of insurers. This format is used nationwide for reporting financial information to insurance regulators. These financial statements do not distinguish IBNR from the bulk reserves. Bulk reserves are established to fund inadequate case reserves or provide an account for excess case reserves. See Exhibit III, Columns 12 and 13.

f. This is not information that is in the possession of the Office.

2. Regarding Market Activity

a. Physicians Professional Liability RRG is a Vermont-domiciled risk retention group that received approval from the Office on April 11, 2003, to begin providing medical malpractice coverage. This entity is currently transacting business in Florida.

There is one pending application for registration for an Arizona domiciled RRG. The name of the entity is Applied Medico-Legal Solutions RRG.

3. Regarding Reserve Audits

a. Schedule P from the annual financial statement provides a summary of reserves and reserve development for all years from the company's inception to date (cumulative). Positive amounts indicate reserves were too low. Negative amounts indicate reserves were too high. See Exhibit III. For the one year development of the reserves since the company's inception, see Column 10. For the two year development of the reserves since the company's inception, See Column 11.

b. N/A

4. Regarding Closed Claim Reporting:

a. The entities required to report closed claims to the Office are specified in Section 627.912, FS. The relevant portions are provided below:

627.912 Professional liability claims and actions; reports by insurers.—
(1) Each self-insurer authorized under ss. 627.357 and each insurer or joint underwriting association providing professional liability insurance to a practitioner of medicine licensed under chapter 458, to a practitioner of osteopathic medicine licensed under chapter 459, to a podiatric physician licensed under chapter 461, to a dentist licensed under chapter 466, to a hospital licensed under chapter 395, to a crisis stabilization unit licensed under part IV of chapter 394, to a health maintenance organization certificated under part I of chapter 641, to clinics included in chapter 390, to an ambulatory surgical center as defined in ss. 395.002, or to a member of The Florida Bar shall report in duplicate to the Department of Insurance any claim or action for damages for personal injuries claimed to have been caused by error, omission, or negligence in the performance of such insured's professional services or based on a claimed performance of professional services without consent, ...

A list of the companies with written premium at some point in the last ten years, and which currently have an active license is attached as Exhibit IV. Please be advised, however, that any of the entities referenced in Section 627.912, FS, that close a medical malpractice claim are required to report such claim to the Office, irrespective of the existence or amount of direct written premium in the year the claim is closed.

b. Entities that fail to report claims to the closed claim database do not report such omissions to the Office. The Office has not completed the development of a process to identify entities that fail to report closed claims to the Office.

c. We could not know what closed claims are not being reported by entities and individuals that are not required to report. We would not know if the underwriting of non-Florida domiciled risk retention groups is comparable to that of admitted insurers. Likewise, we would not know if the underwriting of surplus lines companies is consistent with admitted companies. This information would be critical to estimating what percentage of closed claims is not being reported by those two types of entities. We do know that surplus lines carriers wrote approximately 15 percent of 2002's direct written premium. We also know that risk retention groups wrote about two percent of the 2002 direct written premium. But for the reasons

stated previously, it would be inaccurate to expect these entities to report closed claims at a level commensurate with their respective direct written premium.

5. Regarding Paid Losses vs. Expenses

a. Please see the attached Exhibit III, Columns 5 and 6.
b. Allocated loss adjustment expenses (ALAE) are those expenses that can be directly attributed to a particular claim. Unallocated loss adjustment expenses (ULAE) are claim-related expenses and other expenses that are not attributable to the adjudication of a particular claim. This question can best be answered with providing definitions of loss adjustment expenses.

Loss Adjustment Expenses (LAE) = Allocated Loss Adjusted Expenses (ALAE) + Unallocated Loss Adjustment Expenses (ULAE)

ALAE is defined in the 1998 NAIC Accounting Practices & Procedures Manual as:

- Surveillance expenses.
- Medical cost containment expenses.
- Litigation management expenses.
- LAE for participation in voluntary/involuntary market pools if reported by accident year.
- Fees or salaries for appraisers, private investigators, hearing representatives, re-inspectors and fraud investigators, and rehabilitation nurses.

All ULAE (which now includes claim adjusters) must be assigned to one of 5 expense groups:

- Loss adjustment expenses.
- Acquisition, field supervision, and collection expenses.
- General expenses.
- Taxes, licenses, and fees.
- Investment expenses.

NAIC introduced new reporting requirements for loss adjustment expenses that became effective 1/1/1998. ALAE were deemed by the NAIC to mean expenses, whether internal or external to the company, related to defense, litigation and medical cost containment. ULAE are considered to be all loss expenses not specifically defined as ALAE. All adjuster fees are considered ULAE. Effective with the 1999 Annual Statement, the NAIC changed the titles of these expenses to match the revised

definitions. ALAE became "Defense and Cost Containment" expenses and ULAE became "Adjusting and Other" expenses.
c. The response to this question is under development and will take more time to complete.
d. Yes. To determine if the administrative costs and loss adjustment expenses have increased relative to total losses over the past five years will take some additional research and time.

6. Regarding Accounting Practices

The Office has reviewed the 2002 financial statement of FPIC, the insurance company. This statement reflects net income of $10,961,261, a net underwriting loss of ($6,892,800), and net investment gains of $18,632,979.

It would appear the ($29,578,000) figure referenced within question #6 was extracted from the financial statement of FPIC Insurance Group, a publicly traded company. This holding company owns numerous entities, not all of which transact insurance.

On page 21 of my testimony, reference is made by a committee member to FPIC's 2002 Income Statement reflecting total revenues of $220,865,000, total expenses of $197,155,000 and net losses **or** loss adjustment expenses of $139,571,000.

1) This information is apparently extracted from a financial statement of FPIC Insurance Group, Inc. The Office of Insurance Regulation is responsible for the regulation of FPIC, not the Group.
2) Further, the interpretation of the $139,571,000 expense is incorrect, as the definition of the amount is stated in the Income Statement to be: "Net losses **and** loss adjustment expenses". The key word being "and". Therefore, the summation that this insurance group was paying out approximately $140 million toward loss adjustment expenses and approximately $60 million toward losses is inaccurate.

Thank you for allowing the Office an opportunity to respond. Several of the inquiries will require additional time to develop comprehensive answers. We are working on those answers now and will respond as soon as possible.

It is clear that more information would assist in developing a solution should Florida be faced with another medical malpractice situation sometime in the future. Although we are confident that the resolution that is ultimately adopted will avert another dilemma, we are

anxious to begin compiling whatever additional data may help in the event policymakers want more information if there is a "next time". If not in this Special Session, perhaps in preparation for the 2004 Session, we can work with your staff in drafting legislation that will codify the desired information and authorize the Office to collect it. Please let me know if you would like the Office to work with your staff on developing the additional information that may be helpful in the future.

Sincerely,

J. Steve Roddenberry

JSR:rsr

Attachments

cc: Kevin McCarty, Director, Office of Insurance Regulation

EXHIBIT I

State of Michigan

Department of
Consumer & Industry Services

Insurance Bureau

Financial Examination
of

RONATIONAL INSURANCE COMPANY
Okemos, Michigan

AS OF DECEMBER 31, 1999

DEPARTMENT OF CONSUMER
AND INDUSTRY SERVICES

DIVISION OF INSURANCE
OFFICE OF FINANCIAL AND INSURANCE SERVICES

Certified Copy

Filed as a Public Document
October 16, 2000

Frank M. Fitzgerald
Commissioner of Insurance

REPORT OF EXAMINATION OF

PRONATIONAL INSURANCE COMPANY
Okemos, Michigan

AS OF DECEMBER 31, 1999

TABLE OF CONTENTS

In accordance with Section 222 of the Michigan Insurance Code, the Michigan Division of Insurance produced 48 copies of this report at a total cost of $43.68 or $0.91 each. This cost is funded by assessment fees charged to the insurance companies.

Mr. Alfred W. Gross
Chairperson, Financial Condition (E) Committee
Commissioner of Insurance
State of Virginia
Richmond, Virginia

Mr. Nathaniel S. Shapo, Chair
Midwestern Zone, NAIC
Director of Insurance
State of Illinois
Springfield, Illinois

Mr. Steven B. Larsen, Chair
Northeastern Zone, NAIC
Commissioner of Insurance
State of Maryland
Baltimore, Maryland

Mr. Merwin Stewart, Chair
Western Zone, NAIC
Commissioner of Insurance
State of Utah
Salt Lake City, Utah

Mr. John Oxendine, Chair
Southeastern Zone, NAIC
Commissioner of Insurance
State of Georgia
Atlanta, Georgia

Mr. Frank M. Fitzgerald
Commissioner of Financial
and Insurance Services
State of Michigan
Lansing, Michigan

Commissioners:

In accordance with instructions and pursuant to statutory requirements, we have examined the financial condition, operations and management of the

ProNational Insurance Company
2600 Professionals Drive
Okemos, Michigan

a stock property and casualty insurer, hereinafter referred to as the "Company." Our examination report follows.

SCOPE OF EXAMINATION

The Michigan Division of Insurance conducted an examination of the Company for the period from January 1, 1996 to December 31, 1999. We conducted the examination in accordance with guidelines and procedures recommended by the Financial Condition (E) Committee of the National Association of Insurance Commissioners (NAIC).

We reviewed and incorporated certain workpapers of the Company's independent auditors, PricewaterhouseCoopers LLP, into our examination workpapers, where appropriate.

To determine the adequacy of the Company's reserves and related actuarial items, we hired the actuarial consulting services of William M. Mercer, Inc. The analysis was performed by Alan M. Crowe, FCAS, MAAA. The analysis consisted of the tests necessary to certify the adequacy of

the reserves and related actuarial items. The actuarial certification of William M. Mercer, Inc. is attached to the report of examination as Exhibit 1. The actuary's detailed report is on file at our offices. We have tested the underlying data provided to the actuary for completeness and accuracy.

The Company's assets were verified and liabilities determined as of December 31, 1999. We performed a limited review of the intervening years between the last examination and this December 31, 1999 examination. This review consisted mainly of an analytical review of the changes in the balance sheet and a review of the minutes of the board of directors and annual meeting of the shareholders, or anywhere we deemed it necessary. We also performed a limited market conduct review.

The following matters were also reviewed which have an impact on the Company's financial condition or conformity with related items:

Conflict of Interest
Fidelity Bond and Other Insurance
Policy Forms and Underwriting
Accounts and Records
Complaints

In addition, transactions occurring subsequent to December 31, 1999 were reviewed, where deemed advisable. Comment on the findings of our examination is limited to matters involving a departure from laws, rules or regulations; a significant change in the amount of an item; or where an explanation, comment and/or recommendation is deemed warranted. Any other adjustments or comments were discussed with Company personnel and may appear in a letter to management, which was prepared in conjunction with this report of examination.

HISTORY AND PURPOSE

The Company was organized and commenced business in 1980. The Michigan Division of Insurance issued a preliminary certificate of authority to the Company on June 23, 1980.

The Company was organized as a consequence of the discontinuation of operations of the Brown-McNeely Medical Malpractice Insurance Fund (Fund).

The Fund was established by the Michigan legislature in 1975 to provide medical malpractice insurance to eligible providers. The term of existence of the Fund ceased at July 1, 1980. Section 2506 of the Michigan Insurance Code provided for the transfer of the business, assets and obligations of the Fund subject to stipulated conditions and the approval of the Michigan Insurance Commissioner.

On June 27, 1980, the Michigan Insurance Commissioner signed an order approving the transfer of the assets and obligations of the Fund to the Company.

The Company's certificate of authority authorized the Company to transact the business of insurance, as provided in Chapter 6 (excluding Section 602) of the Michigan Insurance Code.

Effective August 31, 1996 as a result of a holding company restructure, Professionals Group, Inc acquired the Company. Professionals Group, Inc now owns all shares formerly held by individual shareholders.

On July 1, 1998, the Company merged with Physicians Protective Trust Fund, a Florida legislative entity, which wrote medical professional liability coverage. The merger was accounted for as a pooling of interests. All balances in the annual statement have been restated for comparative purposes. The bylaws and certificate of authority were restated and filed with the Michigan Division of Insurance. At that time the Company changed its name from PICOM Insurance Company.

The term of existence of the Company is in perpetuity.

MANAGEMENT AND CONTROL

Holding Company System

The Company is 100 percent owned by Professionals Group, Inc. The group is primarily comprised of the Company, MEEMIC Insurance Company (a Michigan stock company), ProNational Casualty Company (an Illinois company) and American Medical Insurance Exchange (an Indiana company).

ProNational Casualty Company, a wholly owned subsidiary of the Company acquired prior to the holding company reformation, was formerly known as PICOM Insurance Company of Illinois. The Illinois Company was incorporated on December 5, 1994 for the purpose of renewing a book of physician medical malpractice insurance business formerly written by a doctor owned carrier in that state. Effective December 31, 1997, the two companies entered an assumptive reinsurance agreement whereby all of ProNational Casualty's existing business, including loss reserves, LAE reserves and unearned premium reserves were assumed by ProNational Insurance Company. The business, as it renews, is now written on the Company's paper.

The Company owns 77.2 percent of MEEMIC Holdings, Inc. (MEEMIC) and has control of the board of directors. The Company effectively gained control via the purchase of a $21.5 million surplus note in April 1997. From July 1, 1997 to July 1, 1999, the Company also assumed 40 percent of MEEMIC's net written premiums. This agreement was terminated in conjunction with the demutualization of MEEMIC.

The Company is also affiliated with the following non-insurers: ProNational Insurance Agency, Professional Group Services Corporation, MedAdvantage, Inc., PICOM Claims Services Corporation, and Physicians Protective Plan, Inc.

An organizational chart of the Company and its affiliates is shown as Exhibit 2 of this report.

Shareholders

Shareholders are entitled to one vote in person or by proxy for each share of capital stock. A quorum consists of 33.3% of the issued and outstanding shares of the corporation.

The bylaws provide that the annual meeting of the shareholders is held on the first Wednesday in June of each year, unless the board of directors establishes a different date.

Special meetings of the shareholders may be called at any time by the chairman of the board, the president or a majority of the board of directors acting with or without a meeting, or by the president or secretary upon the written request of the holder or holders of record of one-fourth of all shares outstanding and entitled to vote.

Board of Directors

The corporate powers of the Company are exercised by a board of directors elected by the shareholders at the annual meeting. The articles of incorporation and bylaws provide that the board of directors consist of not less than six or more than eighteen directors. Any vacancy on the board of directors occurring between the dates of the meetings shall be filled by a majority vote of the directors in office. A majority of the board constitutes a quorum.

The chairman of the board, the president, or any two directors may call special meetings of the directors at any time.

Directors serving at December 31, 1999 are as follows:

Name	Term Expires	Title/Affiliations
Victor T. Adamo	2000	President and CEO of Company; President, CEO and Director of Professionals Group, Inc.; Director and Chairman of the Board of MEEMIC Insurance Company and MEEMIC Holdings, Inc.
John O. Bashant	2001	Sr. Vice President of Operations Underwriting-North Central Region
Jeffrey L. Bowlby	2002	Sr. Vice President of Marketing & North Central Sales
William D. Baxter	2000	Treasurer and CFO

Annette E. Flood	2001	Sr. Vice President, Corporate Secretary & Legal Counsel of Company; Vice President and Secretary of Professionals Group, Inc.; Director of MEEMIC Insurance Company and MEEMIC Holdings, Inc.
Gregg L. Hanson	2002	Sr. Vice President, Southern Region Operations & Underwriting
John F. Lang	2000	Sr. Vice President of Company; Vice President, Treasurer and CFO of Professionals Group, Inc.
Joseph O. Marker	2001	Sr. Vice President and Chief Actuary of Company; Vice President and Chief Actuary of Professionals Group Inc.
Darryl K. Thomas	2002	Sr. Vice President of Claims–North Central Region
William P. Sabados	2000	Chief Information Officer of Company; Chief Information Officer of Professionals Group, Inc.; Vice President and Chief Information Officer of MEEMIC Insurance Company and MEEMIC Holdings, Inc.

Committees

Pursuant to Article IV of the bylaws, the board of directors may create or appoint an executive committee and any other committee or committees of the board, to consist of not less than three directors. Currently, the Company has no board committees. Several of the parent company committees function as de facto for all subsidiaries. These committees include an executive committee, an investment committee and an audit committee. The Company also has several advisory committees including a claims committee, an underwriting committee and a dental advisory committee.

Officers

The board of directors is authorized by the articles of incorporation and the bylaws to annually elect a chairman of the board, vice chairman or vice chairmen of the board, president, one or more vice presidents, a treasurer, a secretary and such other officers specifically designated as officers by the board of directors.

Elected officers serving at December 31, 1999 are as follows:

Title	Officer
Chairman of the Board	Victor T. Adamo, J.D., C.P.C.U.
Vice Chairman of the Board	Vacant
President	Victor T. Adamo, J.D., C.P.C.U.
Vice President-Operations & Underwriting	John O. Bashant, C.P.C.U.
Vice President – Marketing & Sales	Jeffrey L. Bowlby
Vice President, Secretary, & Legal Counsel	Annette E. Flood, J.D., R.N.
Vice President-Underwriting Operations	Gregg L. Hanson
Vice President	John F. Lang, C.P.A.
Vice President & Chief Actuary	Joseph O. Marker
Vice President & Chief Information Officer	William P. Sabados
Vice President-Claims	Darryl K. Thomas, J.D.
Treasurer & Chief Financial Officer	William D. Baxter, C.P.A

CAPITAL STOCK

The Company has authorized 10,000,000 shares of common capital stock with a par value of $1 per share. As of 12/31/99 the Company had 3,188,145 shares of common capital stock outstanding. The Company's parent owns all shares.

The Company paid a cash dividend of $3,530,334 in 1996, $3,500,000 in 1997, $9,500,000 in 1998, and $12,000,000 in 1999. The Company's board of directors and the Michigan Division of Insurance approved all dividends.

TERRITORY AND PLAN OF OPERATION

The Company is authorized to write business in 19 states.

The Company generates Michigan business through approximately 30 independently licensed agencies and 109 licensed agents in Michigan. Premiums are generated on the direct bill-installment plan option method. The majority of the insureds pay 40 percent down with installments of 30 percent, each due 90 days and 180 days subsequent to the policy inception date.

The home office underwrites all new and renewal risks for Michigan business. Where requested, the underwriting committee, of which the majority is from the board of directors, reviews applicants prior to declination. Any physician wishing to appeal any declination or cancellation may do so.

The Company files rates independently with the Michigan Division of Insurance. Rates are based on territory and risk classifications by specialty. There are two liability limits available for occurrence policies and five for claims-made policies. The occurrence policy limits are $100,000 per incident

with an annual aggregate of $300,000 and $200,000 per incident with an annual aggregate of $600,000. The claims-made policies have the same limits as the occurrence policies along with the following: $300,000 per incident with an annual aggregate of $900,000; $500,000 per incident with an annual aggregate of $1,000,000; and $1,000,000 per incident with an annual aggregate of $3,000,000.

The Company offers an extended reporting period endorsement or "tail" coverage under claims-made policies at no additional cost if the policy is cancelled or not renewed as the result of:

a. The insured's death, or

b. The insured's retirement from active practice after age 55 provided that the insured has been continuously insured with the Company on a claims-made basis for the immediately preceding five years, or

c. The insured's total and continuous disability for at least six months as a result of sickness or accidental bodily injury.

GROWTH OF THE COMPANY

The following is a summary of the growth of the Company from December 31, 1995 to December 31, 1999:

Year	Admitted Assets	Liabilities	Net Capital and Surplus	Net Premiums Written
1995^	$661,185,846	$501,809,760	$159,376,086	$148,252,162
1996^	663,002,641	477,354,198	185,648,443	128,260,966
1997^	724,787,994	503,300,829	221,487,165	169,667,806
1998^	723,895,523	530,001,369	193,894,154	143,921,701
1999*	748,925,678	519,268,853	229,656,825	139,112,110

Year	Net Premiums Written To Surplus	Net Premiums Earned	Losses Incurred	Loss Ratio
1995^	.93:1	$155,028,547	$97,602,100	63.0%
1996^	.69:1	128,796,010	74,951,582	58.2%
1997^	.77:1	138,678,295	75,056,961	54.1%
1998^	.74:1	153,448,646	140,213,375	91.4%
1999*	.61:1	135,905,304	40,180,979	29.6%

Year	Loss Adjustment Expense Incurred	Loss Adjustment Expense Ratio	Other Underwriting Expenses Incurred	Underwriting Expense Ratio	Combined Loss and Underwriting Ratios
1995^	$59,543,852	38.4%	$14,977,506	9.7%	111.1%
1996^	50,414,320	39.1%	16,088,431	12.5%	109.8%
1997^	52,968,609	38.2%	24,811,414	17.9%	110.2%
1998^	41,484,285	27.0%	34,969,780	22.8%	141.2%
1999*	80,783,368	59.4%	28,543,207	21.0%	110.0%

*Per report of examination
^ Amounts have been restated for comparative purposes as a result of the merger with Physicians Protective Trust Fund during 1998.

REINSURANCE

The Company cedes approximately seventeen percent of its premiums written to various reinsurers. The reinsurance program provides coverage for medical malpractice, other liability (lawyers professional liability), and worker compensation exposures.

The Company has a casualty excess of loss contract, which provides coverage for all medical malpractice policies. The contract provides coverage of $4,500,000 of ultimate net loss per insured, per claim, in excess of the Company's retention of $500,000. In addition, the contract provides $1,000,000 of clash coverage above $1,000,000. The policy also provides coverage for extra contractual obligations (ECO) and losses in excess of policy limits (XPL), indemnifying the Company for ninety percent of losses, subject to a maximum recovery of $2,000,000. Towers Perrin Reinsurance is the broker for this agreement and has placed this contract with various reinsurers. Sixty percent of the reinsurers for this treaty are authorized in Michigan.

The Company has a stop loss reinsurance agreement for medical malpractice liability for the 1999 accident year. The reinsurer indemnifies the Company for the aggregate amount of net loss resulting from covered claims in excess of ninety-seven percent of gross earned premium income, with an aggregate limit of liability of thirteen percent of the of reassured's gross net earned premium. Towers Perrin Reinsurance is the broker for this agreement and has placed this contract with two reinsurers, PMA Reinsurance Corporation, an authorized reinsurer and the Underwriters at Lloyds, an unauthorized reinsurer.

In addition, the Company also has a quota share agreement, covering business written in New Jersey and Pennsylvania, net of amounts inuring to the excess of loss contract. Sixty percent of net premiums and losses for New Jersey and Pennsylvania are ceded. The reinsurer's share will not exceed $240,000 on business written in New Jersey, nor more than $300,000 on business written in Pennsylvania. The broker for this agreement is Towers Perrin Reinsurance, which has placed this contract with PMA Reinsurance Corporation, an authorized reinsurer. The Company also

participates in a seventy-five percent quota share contract providing coverage for all claims made professional liability policies covering non-standard medical practitioners. The reinsurer is subject to a maximum of $750,000 per loss (seventy-five percent of $1,000,000). The broker for this agreement, Peglar & Associates Intermediaries, Inc., has placed this contract with three reinsurers, namely TIG Reinsurance Company and Transatlantic Reinsurance Company, authorized reinsurers and Hannover Ruckversicherungs, an unauthorized reinsurer.

The Company also has three facultative agreements providing coverage for groups with limits higher than those typically offered by the Company. In addition, the Company assumes business from and cedes business to Michigan Lawyers Mutual Insurance Company (MLM), an authorized reinsurer. The quota share agreement provides for the Company to assume seventy-five percent of the lawyers professional liability business written by MLM and MLM assumes twenty-five percent of the lawyers professional liability business written by the Company. The Company also assumes all business written subsequent to December 5, 1994 by its affiliate ProNational Casualty Insurance Company. Through July 1, 1999, the Company assumed from its affiliate, MEEMIC Insurance Company, forty percent of MEEMIC Insurance Company's net liability.

PRONATIONAL INSURANCE COMPANY
BALANCE SHEET
As of December 31, 1999

ASSETS	
Bonds	$562,994,516
Preferred Stocks	17,730,449
Common Stocks	96,759,732
Mortgage Loans	270,000
Real Estate	5,588,816
Cash on Hand and on Deposit	5,887,529
Short-term Investments	14,314,733
Other Invested Assets	1,945,494
Agents' Balances	25,404,134
Funds Held by or Deposited with Reinsured Companies	33,808
Reinsurance Recoverables on Loss & LAE Payments	4,343,731
Federal Income Tax Recoverable and Interest Thereon	1,967,422
Electronic Data Processing Equipment	976,861
Interest, Dividends and Real Estate Income Due and Accrued	7,734,753
Receivable from Parent, Subsidiaries and Affiliates	1,139,173
Aggregate Write-ins for Other than Invested Assets	1,834,527
Total Assets	$748,925,678
LIABILITIES, SURPLUS AND OTHER FUNDS	
Losses	$314,902,490
Reinsurance Payable on Paid Loss & LAE	1,427,992
Loss Adjustment Expenses	102,793,607
Other Expenses	3,251,782
Unearned Premiums	46,490,365
Amounts Withheld or Retained by Company for Account of Others	2,491
Remittances and Items not Allocated	5,488,954
Provision for Reinsurance	4,448,712
Excess of Statutory Reserves over Statement Reserves	2,346,000
Drafts Outstanding	8,223,955
Payable for Securities	4,615
Aggregate Write-ins for Liabilities	29,887,890
Total Liabilities	$519,268,853
Common Capital Stock	$ 3,188,145
Surplus Notes	10,093,603
Gross Paid-in and Contributed Surplus	27,978,790
Unassigned Funds (Surplus)	188,396,287
Surplus as Regards Policyholders	$229,656,825
Total Liabilities, Surplus & Other Funds	$748,925,678

PRONATIONAL INSURANCE COMPANY
SUMMARY OF OPERATIONS
For Year Ending December 31, 1999

UNDERWRITING INCOME	
Premiums Earned	$135,905,304
Losses Incurred	$ 40,180,979
Loss Expenses Incurred	80,783,368
Other Underwriting Expenses Incurred	28,543,207
Aggregate Write-ins for Underwriting Deductions	2,668,695
Total Underwriting Deductions	$152,176,249
Net Underwriting Loss	$(16,270,945)
INVESTMENT AND OTHER INCOME	
Investment Income	
Net Investment Income	$ 36,247,102
Net Realized Capital Gains	2,721,491
Net Investment Gain	$ 38,968,593
Other Income	
Net Loss from Agents' or Premium Balances Charged Off	$ (35,715)
Finance and Service Charges not Included in Premiums	448,525
Aggregate Write-ins for Miscellaneous Income	116,973
Total Other Income	$ 529,783
Net Income Before Dividends to Policyholders and Before Federal and Foreign Income Taxes	$ 23,227,431
Dividends to Policyholders	$ 0
Net Income After Dividends to Policyholders but Before Federal and Foreign Income Taxes	$ 23,227,431
Federal and Foreign Income Taxes Incurred	(1,288,813)
Net Income	$ 21,938,618

PRONATIONAL INSURANCE COMPANY
CAPITAL AND SURPLUS ACCOUNTS RECONCILIATION
For Year Ending December 31, 1999

Policyholder Surplus, December 31, 1998	$193,894,154
GAINS AND LOSSES ( ) IN SURPLUS	
Net Income	$ 21,938,618
Net Unrealized Capital Gains	30,442,126
Change in Non-Admitted Assets	(1,383,361)
Change in Provision for Reinsurance	(888,712)
Change in Excess Statutory Reserves over Statement Reserves	(2,346,000)
Dividends to Stockholders	(12,000,000)
Change in Policyholder Surplus for the Year	$ 35,762,671
Policyholder Surplus, December 31, 1999	$229,656,825

PRONATIONAL INSURANCE COMPANY
CASH FLOW STATEMENT
For Year Ending December 31, 1999

Premiums Collected Net of Reinsurance	$ 144,479,451
Losses and Loss Adjustment Expenses Paid	(137,085,431)
Underwriting Expenses Paid	(28,000,217)
Other Underwriting Income	208,951
Cash from Underwriting	$ (20,397,246)
Investment Income	40,972,473
Other Income	475,772
Federal Income Taxes Paid	(2,425,207)
Net Cash from Operations	$ 18,625,792
Proceeds from Investments Sold, Matured or Repaid:	
Bonds	$ 273,914,208
Stocks	18,400
Mortgage Loans	7,426
Other Invested Assets	23,865,432
Net Loss on Cash & Short-term Investments	(635)
Total Proceeds from Investments Sold	$ 297,804,831
Total Other Cash Provided	$ 0
Cost of Investments Acquired:	
Bonds	$ (238,112,200)
Stocks	(53,162,130)
Other Invested Assets	(1,945,494)
Miscellaneous Applications	(6,796,111)
Total Cost of Investments Acquired	$ (300,015,935)
Other Cash Applied:	
Dividends to Stockholders Paid	$ (12,000,000)
Net Transfers to Affiliates	(860,050)
Other Application	(622,265)
Total Other Cash Applied	$ (13,482,315)
Net Change in Cash and Short-term Investments	$ 2,932,373
RECONCILIATION:	
Cash and Short-term Investments:	
Beginning of Year	$ 17,269,889
End of Year	$ 20,202,262

PRONATIONAL INSURANCE COMPANY
NOTES TO FINANCIAL STATEMENTS
As of December 31, 1999

Basis of Presentation and Significant Accounting Policies

General
The Company is a licensed property and casualty insurance company providing professional liability insurance for physicians, surgeons, dentists, hospitals, other health care providers, and lawyers and law firms in the State of Michigan and eighteen other states.

Basis of Presentation
The accompanying statutory financial statements have been prepared on the basis of accounting practices prescribed or permitted by the National Association of Insurance Commissioners and/or Michigan Division of Insurance. These practices differ in some respects from generally accepted accounting principles (GAAP) followed by other business enterprises in determining financial position and results of operations. The more significant differences are: 1) policy acquisition costs are charged against operations as incurred rather than deferred and amortized; 2) bonds are valued at amortized costs without regard to whether they will be held to maturity; 3) adjustments reflecting the equity of earnings of affiliated companies are carried to the surplus account as net unrealized capital gains or losses rather than income; 4) adjustments reflecting the revaluation of stocks and bonds are carried to the surplus account as unrealized investment gains or losses, without provision for federal income taxes or income tax reductions; 5) certain assets are designated as "non-admitted assets" (principally computer software, office furniture and equipment and prepaid expenses) and are charged to surplus; 6) deferred federal income taxes are not provided for statutory reporting purposes; 7) majority-owned subsidiaries are not consolidated; 8) a provision for statutory liabilities with respect to unearned premiums and losses reinsured with unauthorized reinsurers, to the extent funds are not held is charged directly against policyholder surplus; 9) loss, loss adjustment expenses and unearned premiums are reported net, rather than gross, of reinsured amounts; and 10) commissions allowed by reinsurers on business ceded are reported as income when written.

In preparing the statutory financial statements, management is required to make estimates and assumptions that affect the reported amounts of admitted assets and liabilities as of the dates of the statement of admitted assets, liabilities, and surplus, and revenues and expenses for the periods then ended. Actual results may differ from those estimates. Material estimates that are susceptible to significant change in the near term include the determination of loss and loss adjustment expense reserves and the reserve for extended reporting period claims.

Investments
Bonds and stocks are valued in accordance with rules promulgated by the NAIC. Bonds and redeemable preferred stock are stated at amortized cost using the scientific method; common stocks of non-affiliates are stated at market value; common stocks of unconsolidated subsidiaries

and affiliates in which the Company has an interest of 20% or more are stated at equity value; short-term investments are stated at cost, which approximates market value. The market value of investments represent quoted market prices from the NAIC or other published sources.

Premiums and discounts are amortized or accreted, respectively, over the life of the related debt security as an adjustment to yield using the yield-to-maturity method. Realized gains and losses on investments are included in earnings and are derived using the specific-identification method for determining the cost of securities sold; unrealized gains and losses on common stocks increase or decrease accumulated surplus.

Revenue Recognition
Insurance premium income is recognized on monthly pro rata basis over the respective terms of the policies, and unearned premiums represent the portion of premiums written which are applicable to the unexpired terms of the policies in force.

Reinsurance arrangements are prospective contracts for which prepaid reinsurance premiums are amortized ratably over the related policy terms based on the estimated ultimate amounts to be paid.

Through 1995, reinsurance agreements on the Company's Florida business included profit sharing provisions whereby premiums were refunded to the Company after an established period of time if they exceeded actual losses incurred plus an allowance for expenses. Interest income is also accrued on excess premiums paid. In prior years, the Company's independent actuary based the amount of profit recognized in income on ultimate loss projections established. The Company recognized reinsurance profits when losses developed favorably. During 1998, the 1991 and prior reinsurance contracts were commuted and deferred reinsurance profits thereon were recognized.

Depreciation
Property and equipment, consisting of real estate, data processing equipment and furniture and fixtures, are recorded at cost, net of accumulated depreciation. Depreciation is computed on the straight-line method over periods ranging from 4 to 25 years. Maintenance, repairs and minor renewals are charged to expense as incurred.

The cost and related accumulated depreciation of assets sold are removed from related accounts and the resulting gain or loss is reflected as income.

Intangible Assets
Intangible assets are comprised mainly of goodwill, which represents the excess of cost over the fair value of assets acquired, and the cost of a purchased book of business. Intangible assets are amortized on a straight-line basis over ten years. The Company, based on the expected future undiscounted operating cash flows of the related item, periodically reviews the carrying value of intangible assets. Based upon its most recent analysis, the Company believes that no material impairment of intangible assets exists at December 31, 1999.

Loss and Loss Adjustment Expense Reserves

Loss and loss adjustment expense reserves represent the accumulation of individual case estimates for reported losses and loss adjustment expenses, bulk adjustments to case estimates and actuarial estimates for incurred but not reported losses and loss adjustment expenses, based upon the Company's actual experience, assumptions and projections as to claims frequency, severity, inflationary trends and settlement payments. Additionally, the Company provides for loss and loss adjustment expense reserves on assumed business based on information received from the ceding companies. The reserve for loss and loss adjustment expenses is intended to cover the ultimate net cost of all losses and loss adjustment expenses incurred but unsettled through the balance sheet date.

Reserve for Extended Reporting Period Claims

The reserve for extended reporting period claims coverage is recorded during the term of the original claims-made policy, utilizing the pure-premium approach, in amounts believed to be adequate to pay for estimated future claims reported subsequent to a current policyholder's death, disability or retirement. Changes in this reserve are charged or credited to income.

Federal Income Taxes

The Company files a consolidated Federal Income Tax return with its parent, Professionals Group, Inc. and its affiliates. The method of allocation between the companies is subject to written agreement, approved by the Board of Directors. Allocation is based upon separate return calculations as they bear to the total taxes of the group.

The amount of federal income taxes incurred and available for recoupment in the event of future net losses is $1,289,000 for the current year and $1,097,000 for the second preceding year. The amount of net losses carried forward and available to offset future net income subject to federal income taxes is $11,253,000 in the first preceding year.

Employee Benefit Plans

The Company currently maintains two defined contribution employee benefit plans – a 401(k) plan and an Employee Stock Option Plan (ESOP), which cover substantially all employees meeting certain eligibility requirements.

With respect to the 401(k) plan, the Company annually contributes 5 percent of an employee's salary and matches employee contributions up to 5 percent of an employee's salary. During 1999 the Company's expense under the 401(k) plan was $796,000.

With respect to the ESOP, the Company annually contributes 3 percent of an employee's salary. During 1999, the Company's expense under the ESOP was $310,000.

The Company also has a stock purchase plan through which employees and directors of the Company and its wholly owned subsidiaries may purchase Professionals Group common stock by means of payroll deduction. Pursuant to this plan, the Company may elect to match participant purchases, which it is currently matching at the rate of $1.00 for each $1.00 of participant purchases up to $4,000 plus $.50 for each $1.00 of participant purchases in excess of $4,000 up to a maximum participant purchase of $6,000 per year. In 1999, the Company incurred expenses of $387,000 under this plan.

Capital and Surplus and Restrictions Thereon

The maximum amount of dividends, which can be paid by the Company to its shareholder without prior approval of the Commissioner of Financial and Insurance Services, is $22,966,000. Dividends are non-cumulative and are paid as determined by the Board of Directors. In 1999, two cash dividends of $6,000,000 each were paid to Professionals Group.

Concentrations and Credit Risk

In 1999, premiums written through independent agents approximated 56% of the Company's direct written premiums. The top ten agents produced, in aggregate, approximately 31% of the Company's direct written premiums.

All premiums are directly billed to policyholders, and premiums due are secured by the related unearned premiums. When insureds fail to pay their premiums, coverage is canceled. Premiums are collected in advance of being earned. Subsequent scheduled payments are monitored to prevent the Company from providing coverage beyond the date for which payment has been received. In the opinion of management, the amounts carried on the consolidated balance sheets are collectible.

Subsequent Events

On June 23, 2000, the Company's parent announced a definitive agreement to consolidate with Medical Assurance, Inc., a medical malpractice insurance group domiciled in Alabama. The agreement is subject to regulatory and shareholder approvals. Completion of the merger is anticipated for early 2001.

EXAMINATION FINDINGS AND RECOMMENDATIONS

1. *Broker as Custodian*

Securities approximating $683,000 are maintained with a brokerage firm in violation of Section 5256(3) of the Michigan Insurance Code. Section 5256(3) of the Michigan Insurance Code allows only national banks, state banks or trusts regulated by the Federal Reserve to serve as custodians. When companies use brokers as custodians, the companies are not afforded the same protection of their assets. Prudent business practices dictate that the Company implements a custodial agreement with an approved custodian to protect the Company's assets. The agreement should require the custodian, in the event of a loss, to indemnify the Company and replace securities promptly.

We recommend the Company comply with Section 5256(3) of the Michigan Insurance Code and place investments with qualified custodians. In order to comply, the Company subsequently transferred the securities to an authorized custodian.

CONCLUSION

This examination as of December 31, 1999 disclosed the Company to have admitted assets of $748,925,678, liabilities of $519,268,853, and surplus of $229,656,825.

Appreciation is expressed for the cooperation and assistance extended by the officers and employees of the Company during the course of the examination.

In addition to the undersigned, Abigail L. Perry, Robert D. Macdowall, and Jason A. Tippett, examiners of the Michigan Division of Insurance, and William M. Mercer, Inc., contracted actuary, participated in the examination.

Respectfully submitted,

Kristin M. Hynes
Examiner-in-Charge
Michigan Division of Insurance

The examination process has been monitored and supervised by the undersigned. The examination report and supporting workpapers have been reviewed and approved. Compliance with NAIC procedures and guidelines as contained in the Financial Condition Examiners Handbook has been confirmed.

Respectively submitted,

Robert C. Lambefjack, CFE
Chief Examiner
Michigan Division of Insurance

Exhibit 1

Opinion Letter

I, Alan M. Crowe, FCAS, MAAA, am associated with the firm William M. Mercer, Incorporated. I am a Fellow of the Casualty Actuarial Society and a Member of the American Academy of Actuaries.

I have examined the reserves listed below as shown in the Annual Statement of ProNational Insurance Company (ProNational) as prepared for filing with state regulatory officials, as shown as of December 31, 1999.

A.	Reserve for unpaid losses - (Page 3, Item 1);	$314,902,490
B.	Reserves for unpaid loss adjustment expenses (Page 3, Item 2);	$102,793,607
C.	Reserve for unpaid losses - Direct and Assumed (Schedule P, Part 1 Summary {Totals from Columns 13 and 15}); and	$426,701,000
D.	Reserve for unpaid loss adjustment expenses - Direct and Assumed (Schedule P, Part 1 Summary {Totals from Columns 17, 19, and 21}).	$119,088,000

The reserve items as shown above on which I am expressing an opinion reflect the following:

A. Anticipated salvage and subrogation as a reduction to loss reserves as reported in Schedule P - Analysis of Losses and Loss Expenses, Underwriting and Investment Exhibit - Part 3A and on Page 3 - Liabilities, Surplus and Other Funds, Line 1, $0;

B. Discount for time value of money included as a reduction to loss reserves and loss expense reserves as reported in Schedule P - Analysis of Losses and Loss Expenses, Part 3A - Underwriting and Investment Exhibit, and on Page 3 -Liabilities, Surplus and Other Funds, Lines 1 and 2, nontabular discount $0 and tabular discount $0;

Opinion Letter (cont)

C. The net reserves for loss and expense for the company's share of underwriting pools and associations unpaid losses and expenses are included in reserves shown on Page 3 - Liability, Surplus and Other Funds, Lines 1 and 2, $0;

D. The net reserves for loss and expense that the company carries for asbestos liabilities, $0, and environmental liabilities, $0, which are included in reserves shown on Page 3 - Liability, Surplus and Other Funds, Lines 1 and 2, and disclosed in the Notes to Financial Statements;

In forming my opinion on the loss and loss adjustment expense reserves, I have relied on ProNational's annual statements as of December 31, 1993 through 1999 and the Tillinghast-Towers Perrin opinion letter as of December 31, 1999 as well as workpapers for the Tillinghast-Towers Perrin report as of December 31, 1999. I reviewed the data for reasonableness and consistency. In addition, we have referenced industry data from the 1999 edition of Best's Aggregates and Averages. In other respects, my examination included such review of the actuarial assumptions and methods used and such tests of the calculations as I considered necessary.

My review was limited to items A, B, C, and D above and did not include an analysis of any income statement items or other balance sheet items. My opinion is based upon the assumption that all reserves are backed by valid assets, which have suitably scheduled maturities and/or adequate liquidity to meet cash flow requirements.

According to the opining actuary's report, he is not aware of any reinsurance transaction that either has been or should have been accounted for as loss portfolio transfer or financial reinsurance.

According to the opining actuary's opinion, he is not aware of any unearned premium for long duration contracts.

According to the opining actuary's opinion, he is not aware of any uncollectible reinsurance.

According to the opining actuary's opinion, the chance of the Company's exposure to material liability relating to asbestos and environmental claims is remote.

According to the opining actuary's opinion, the Company's exposure to voluntary and involuntary pools is minimal.

The Company does not discount loss and loss adjustment expense reserves.

Opinion Letter (cont)

Reserves are established gross of anticipated salvage and subrogation.

In my opinion, the amounts recorded in the Annual Statement for the sum of items A and B as well as the sum of items C and D:

A. Meet, to the best of my knowledge, the requirements of the insurance laws of the domiciliary state of Michigan.

B. Are consistent with amounts computed in accordance with the Casualty Actuarial Society Statement of Principles Regarding Property and Casualty Loss and Loss Adjustment Expense Reserves and relevant standards of practice promulgated by the Actuarial Standards Board.

C. Make a reasonable provision for all unpaid loss and loss expense obligations of the Company under the terms of its policies and agreements.

Insurance laws and regulations shall at all times take precedence over the actuarial standards and principles.

Alan M. Crowe, FCAS, MAAA
William M. Mercer, Incorporated
10 West Broad Street
Columbus, Ohio 43215-3475
June 16, 2000

PRONATIONAL INSURANCE COMPANY Exhibit 2

SCHEDULE Y – INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY

PART 1 - ORGANIZATIONAL CHART

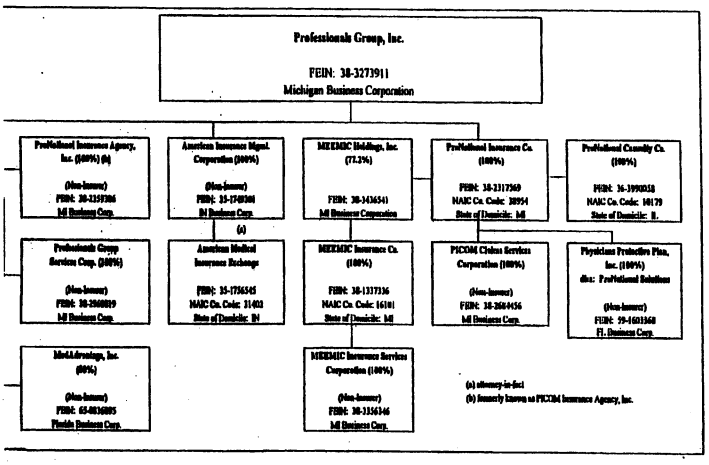

EXHIBIT II

Exhibit 1

Case Incurred Losses including ALAE

($ 000's omitted)

Earned Premiums Net of Commission	Accident Year	Development First Report	Second Report	Third Report	Fourth Report	Fifth Report	Sixth Report
5,000	1966	2,500	3,650	4,200	4,325	4,335	4,330
5,500	1967	2,150	3,225	3,775	3,965	3,960	
6,000	1968	3,250	4,500	5,050	5,150		
7,000	1969	3,700	5,200	5,775			
7,500	1970	3,300	4,800				
8,000	1971	4,250					

Accident Year	Age-to-Age LDFs 1-2 Report	2-3 Report	3-4 Report	4-5 Report	5-6 Report
1966	1.460	1.151	1.030	1.002	0.999
1967	1.500	1.171	1.050	0.999	
1968	1.385	1.122	1.020		
1969	1.405	1.111			
1970	1.455				

Exhibit 2

Method 1:
IBNR Reserve Calculation
(as of 12/31/71)
as a function of expected losses

Development Period	Three Year Data Beginning	Three Year Data Ending	Selected LDFs	Age-to Ultimate LDFs
	(1)	(2)	(3)=(2)/(1)	(4)
1st-2nd	$10,250	$14,500	1.415	1.649
2nd-3rd	12,925	14,600	1.130	1.166
3rd-4th	13,025	13,440	1.032	1.032
4th-Ult	8,290	8,290	1.000	1.000

4th-ultimate LDF is smoothed (as in BF paper)

Accident Year	Earned Premiums	Expected Losses	Expected Losses IBNR factor	Indicated IBNR
	(5)	(6)=(5)x.95	(7)=1-[1/(4)]	(8)=(7) x (6)
1971	$8,000	$7,600	0.394	$2,991
1970	7,500	7,125	0.142	1,012
1969	7,000	6,650	0.031	205
1968	6,000	5,700	0.000	0
Total				**$4,208**

Column (4) Based on Column (3)
Column (6) Based on an expected loss ratio = 95%

Exhibit 3

Method 2:
IBNR Reserve Calculation
(as of 12/31/71)
as a function of case incurred losses

Development Period	Three Year Data Beginning	Three Year Data Ending	Selected LDFs	Age-to Ultimate LDFs
	(1)	(2)	(3)=(2)/(1)	(4)
1st-2nd	$10,250	$14,500	1.415	1.649
2nd-3rd	12,925	14,600	1.130	1.166
3rd-4th	13,025	13,440	1.032	1.032
4th-Ult	8,290	8,290	1.000	1.000

4th-ultimate LDF is smoothed (as in BF paper)

Accident Year	Case Incurred Losses as of 12/31/71	IBNR Factor	Loss Method IBNR	Estimated Ultimate Losses
	(5)	(6)=(4)-1	(7)=(5)x(6)	(8)=(5)+(7)
1971	$4,250	0.649	$2,758	$7,008
1970	4,800	0.166	795	5,595
1969	5,775	0.032	184	5,959
1968	5,150	0.000	0	5,150
Total			**$3,737**	**$23,712**

Column (4) Based on (3)
Column (5) From Exhibit 1

Exhibit 4

Method 2: A refinement
IBNR Reserve Calculation
(as of 12/31/71)
"smoothing out" case incurred loss data

Development Period	Three Year Data Beginning	Three Year Data Ending	Selected LDFs	Age-to Ultimate LDFs
	(1)	(2)	(3)=(2)/(1)	(4)
1st-2nd	$10,250	$14,500	1.415	1.649
2nd-3rd	12,925	14,600	1.130	1.166
3rd-4th	13,025	13,440	1.032	1.032
4th-Ult	8,290	8,290	1.000	1.000

4th-ultimate LDF is smoothed (as in BF paper)

Accident Year	Earned Premiums	Average Exposure (AE)	Relative Diff. Between the Current and AE	Average Case Incurred For Same Report	Factor	Adjusted Loss Method IBNR
	(5)	(6)	(7)=(5)/(6)	(8)	(9)	(10)=(9)x(8)x(7)
1971	$8,000	$7,750	1.032	$3,775	0.649	$2,529
1970	7,500	7,250	1.034	5,000	0.166	859
1969	7,000	6,500	1.077	5,413	0.032	187
1968	6,000	5,750	1.043	4,558	0.000	0
Total						**$3,574**

Column (7) Current exposure is the earned premium for the accident year for which IBNR is being calculated
Column (8) From Exhibit 1, averaged values

Exhibit 5

Reconciliation of Method 1 and Method 2:
IBNR Reserve Calculation
(as of 12/31/71)
as a function of expected losses

Development Period	Three Year Data Beginning	Three Year Data Ending	Selected LDFs	Age-to Ultimate LDFs
	(1)	(2)	(3)=(2)/(1)	(4)
1st-2nd	$10,250	$14,500	1.415	1.649
2nd-3rd	12,925	14,600	1.130	1.166
3rd-4th	13,025	13,440	1.032	1.032
4th-Ult	8,290	8,290	1.000	1.000

4th-ultimate LDF is smoothed (as in BF paper)

Accident Year	Earned Premiums	Expected Losses	Expected Losses IBNR factor	Indicated IBNR
	(5)	(6)	(7)=1-[1/(4)]	(8)=(7) x (6)
1971	$8,000	$7,008	0.394	$2,758
1970	7,500	5,595	0.142	795
1969	7,000	5,959	0.031	184
1968	6,000	5,150	0.000	0
Total				**$3,737**

Column (4) Based on Column (3)
Column (6) From Exhibit 3 (column (8)), estimates based on the loss development method

Exhibit 6

Method 3: Modified Bornhuetter-Ferguson (Stanard Method #2)

Accident Year	Case Incurred Losses at 12/31/71	Age-to-Ultimate LDFs	Estimated Ultimate Losses	Expected Losses	Percentage Unreported	Estimated IBNR
	(1)	(2)	(3)=(1)x(2)	(4)=$5,928	(5)=1.00-1.00/(2)	(6)=(4)x(5)
1971	$4,250	1.649	$7,008	$5,928	39.4%	$2,333
1970	4,800	1.166	5,595	5,928	14.2%	842
1969	5,775	1.032	5,959	5,928	3.1%	183
1968	5,150	1.000	5,150	5,928	0.0%	0
Total	$19,975		$23,712	$23,712		**$3,358**
Average	$4,994		$5,928	$5,928		

Column (1) From Exhibit 1
Column (2) From Exhibit 2
Column (3) Based on the loss development method (Exhibit 3)
Column (4) Based on Stanard's notation:
R5 = $5,928
Column (5) Expected loss IBNR factor

Note: How would we have to change this Exhibit to show the Modified B-F method **as applied by Stanard?** This is an extremely important question. See **Exhibit 6a** for the solution.

Exhibit 6a

Method 4: Modified Bornhuetter-Ferguson (Stanard Method #2)
(According to Stanard)

Accident Year	Case Incurred Losses at 12/31/71	Age-to-Ultimate LDFs	Estimated Ultimate Losses	Expected Losses	Percentage Unreported	Estimated IBNR
	(1)	(2)	(3)=(1)x(2)	(4)=$5,356	(5)=1.00-1.00/(2)	(6)=(4)x(5)
1971	$4,250	1.678	$7,132	$5,356	40.4%	$2,164
1970	4,800	1.170	5,615	5,356	14.5%	777
1969	5,775	1.031	5,956	5,356	3.0%	163
1968	5,150	0.999	5,147	5,356	-0.1%	(3)
1967	3,960	0.999	3,955	5,356	-0.1%	(6)
1966	4,330	1.000	4,330	5,356	0.0%	0
Total	$28,265		$32,135	$32,135		**$3,095**
Simple Aver.			$5,356	$5,356		

Column (1) From Exhibit 1
Column (2) All-year loss weighted averages
Column (3) Based on the loss development method
Column (4) Based on Stanard's notation:
R5 = $5,356
Column (5) Expected loss IBNR factor

Note: As applied by Stanard, all years experience must be used in the calculation, even if the year is almost fully developed already (e.g., Accident Years 1966-1968). Stanard always creates the **broadest possible averages.**

Exhibit 7

Method 4: Adjustment to Total Known Losses (Cape Cod)

Accident Year	Case Incurred Losses at 12/31/71	Age-to-Ultimate LDF	Percent Reported	Expected Ultimate Losses	Percentage Unreported	Estimated IBNR
	(1)	(2)	(3)=1/(2)	(4)=$5,818	(5)= 1.00-(3)	(6)=(4)x(5)
1971	$4,250	1.649	60.6%	$5,818	39.4%	$2,289
1970	4,800	1.166	85.8%	5,818	14.2%	826
1969	5,775	1.032	96.9%	5,818	3.1%	180
1968	5,150	1.000	100.0%	5,818	0.0%	0
Total	$19,975		n/a	$23,270		**$3,295**
Average	$4,994		85.8%	$5,818		

Column (1) From Exhibit 1
Column (2) From Exhibit 2
Column (4) Based on Stanard's notation:
R5= $5,818
($4,994/.858)

Note: How would we have to change this Exhibit to show the Cape Cod method as applied by Stanard? This is an extremely important question. See **Exhibit 7a** for the solution.

Exhibit 7a

Method 4: Adjustment to Total Known Losses (Cape Cod)
(According to Stanard)

Accident Year	Case Incurred Losses at 12/31/71	Age-to-Ultimate LDFs	Percent Reported	Expected Ultimate Losses	Percentage Unreported	Estimated IBNR
	(1)	(2)	(3)=1/(2)	(4)=$5,213	(5)= 1.00-(3)	(6)=(4)x(5)
1971	$4,250	1.678	59.6%	$5,213	40.4%	$2,106
1970	4,800	1.170	85.5%	5,213	14.5%	756
1969	5,775	1.031	97.0%	5,213	3.0%	158
1968	5,150	0.999	100.1%	5,213	-0.1%	(3)
1967	3,960	0.999	100.1%	5,213	-0.1%	(6)
1966	4,330	1.000	100.0%	5,213	0.0%	0
Total	$28,265		542.2%	$31,277		**$3,012**
Simple Aver.	$4,711		90.4%	$5,213		

Column (1) From Exhibit 1
Column (2) All-year loss weighted averages
Column (4) Based on Stanard's notation:
R5= $5,213
($4,711/.904)

Note: As applied by Stanard, all years experience must be used in the calculation, even if the year is almost fully developed already (e.g., Accident Years 1966-1968). Stanard always creates the **broadest possible averages.**

Exhibit 8

Method 5: Percentage of Premium Method

Development Period	Most Recent Observation	First Prior Observation	Second Prior Observation	Selected Factor
	(1)	(2)	(3)	(4)
12 - 24	0.200	0.214	0.208	0.207
24 - 36	0.082	0.092	0.100	0.091
36 - 48	0.017	0.035	0.025	0.026
48 - 60	-0.001	0.002	0.000	0.000

Development Period	Percentage of Premium Method IBNR Factor	Accident Year	Earned Premium	Estimated IBNR Required
	(5)		(6)	(7)=(5)x(6)
12 to ult	0.324	1971	$8,000	$2,595
24 to ult	0.117	1970	7,500	878
36 to ult	0.026	1969	7,000	180
48 to ult	0.000	1968	6,000	0
Total				$3,652

Columns (1), (2), (3) For Example, 12-24 first observation. From Exhibit 8a take (4,800 - 3,300) / 7,500

Column (4) Simple average of (1), (2), (3)

Column (5) Upward additive accumulation of Column (4)

Note: How would we have to change this Exhibit to show the Percent of Premium method **as applied by Stanard?** This is an extremely important question. See **Exhibit 8a** for the solution.

Exhibit 8a

Method 5: Percentage of Premium Method

According to Stanard (Additive Method)

Development Period	Most Recent Observation	First Prior Observation	Second Prior Observation	Third Prior Observation
	(1)	(2)	(3)	(4)
12 - 24	$1,500	$1,500	$1,250	$1,075
24 - 36	575	550	550	550
36 - 48	100	190	125	n/a
48 - 60	(5)	10	n/a	n/a
60 - ult	(5)	n/a	n/a	n/a

Development Period	Fourth Prior Observation	Selected Increment	Estimated IBNR
	(5)	(6)	(7)
12 - 24	$1,150	$1,295.0	$1,987.1
24 - 36	n/a	556.3	692.1
36 - 48	n/a	138.3	135.8
48 - 60	n/a	2.5	(2.5)
60 - ult	n/a	(5.0)	(5.0)
Total			$2,808

Columns (1) to (5) For Example, 12-24 first observation. From Exhibit 8a take (4,800 - 3,300)

Column (6) Simple average of (1) to (5)

Column (7) Upward additive accumulation of Column (6)

Note: As applied by Stanard, all years experience must be used in the calculation, even if the year is almost fully developed already (e.g., Accident Years 1966-1968). Stanard always creates the broadest possible averages.

Exhibit 8b

Case Incurred Losses including ALAE

($ 000's omitted)

Earned Premiums Net of Commission	Accident Year	Development First Report	Second Report	Third Report	Fourth Report	Fifth Report	Sixth Report
5,000	1966	2,500	3,650	4,200	4,325	4,335	4,330
5,500	1967	2,150	3,225	3,775	3,965	3,960	
6,000	1968	3,250	4,500	5,050	5,150		
7,000	1969	3,700	5,200	5,775			
7,500	1970	3,300	4,800				
8,000	1971	4,250					

Percent of Premium Age-to-Age Factors

Accident Year	1-2 Report	2-3 Report	3-4 Report	4-5 Report	5-6 Report
1966	0.230	0.110	0.025	0.002	-0.001
1967	0.195	0.100	0.035	-0.001	
1968	0.208	0.092	0.017		
1969	0.214	0.082			
1970	0.200				

Replacement Exhibit 9

Method: Stanard-Buhlmann (From Patrik)

Accident Year	Earned Premium	Case Incurred Losses at 12/31/71	Age-to-Ultimate LDFs	Percentage Reported	Burned Premium	Percentage Unreported	Estimated IBNR
	(1)	(2)	(3)	(4)=1.0/(3)	(5)=(1)x(4)	(6)=1.00-(4)	(7)=(1)x83%x(6)
1971	$8,000	$4,250	1.649	60.6%	$4,852	39.4%	$2,613
1970	7,500	4,800	1.166	85.8%	6,435	14.2%	884
1969	7,000	5,775	1.032	96.9%	6,784	3.1%	179
1968	6,000	5,150	1.000	100.0%	6,000	0.0%	0
Total	$28,500	$19,975			$24,070		$3,676

Loss Ratio Selection **83.0%** (19,975/24,070)

Column (1) From Exhibit 1

Column (2) From Exhibit 1

Column (3) From Exhibit 2

Column (5) The term "Burned Premium" is not used by Patrik

Exhibit 10

Summary of Results			
Exhibit	Method	Name	Estimated IBNR
2	1	**Expected loss method**	$4,208
3	2	**Loss development method**	$3,737
4	2a	**Refined loss development method**	$3,574
	3	**Modified expected loss method**	
6		Intuitive calculation	$3,358
6a		According to Stanard	$3,095
	4	**Adjustment to total known losses method**	
7		Intuitive calculation	$3,295
7a		According to Stanard	$3,012
	5	**Percent of premium method**	
8		Fisher/Lester calculation	$3,652
8a		According to Stanard	$2,808

Exhibit 11

Comparison of Methods - Summary Chart

Loss Ratio	Reserve Strengthening	Loss Development Method (LD) *	Expected Loss Method (EL)	Percentage of Premium Method (PP)
Deteriorating	NO	Gives best estimate. No dependence on premiums.	Estimate is too low. Same estimate as "static". Will not change unless a decision is made to revise the expected LR.	Provides an estimate between LD and EL. Tends to be "self-correcting".
Estimated IBNR		**$1,661,653**	**$1,300,320**	**$1,455,400**
Consistent	YES	IBNR is overstated. LD Method is most susceptible to distortions from changes in reserve adequacy	IBNR is overstated. The distortion is less than with LD.	IBNR is overstated. The distortion is less than with LD, but greater than with EL
	See Exhibits 11a-e For Detail			
Estimated IBNR		**$1,469,150**	**$1,391,400**	**$1,395,600**
Deteriorating	YES	IBNR is overstated. LD Method is most susceptible to distortions from changes in reserve adequacy	IBNR is too low. EL reacts slowest to deteriorating LR.	IBNR is too low. However, not as slow reacting as EL.
Estimated IBNR		**$1,881,566**	**$1,391,400**	**$1,562,200**
		IBNR is proportional to reported losses. **KEY: Leverage**	IBNR is "independent" of reported losses. **KEY: No Leverage**	IBNR by AY is "independent" of reported losses in that AY (Most recent AY reported losses are not used)

* Key assumption is that case reserves are at the same relative level of adequacy.

Exhibit 11a

After Reserve Strengthening

Case Incurred Losses including ALAE

($ 000's omitted)

Earned Premiums Net of Commission	Accident Year	Development First Report	Second Report	Third Report	Fourth Report	Fifth Report	Sixth Report
5,000	1966	2,500	3,650	4,200	4,325	4,335	*4,330*
5,500	1967	2,150	3,225	3,775	3,965	*3,960*	
6,000	1968	3,250	4,500	5,050	*5,150*		
7,000	1969	3,700	5,200	*5,867*			
7,500	1970	3,300	*5,197*				
8,000	1971	*5,629*					

Age-to-Age LDFs

Accident Year	1-2 Report	2-3 Report	3-4 Report	4-5 Report	5-6 Report
1966	1.460	1.151	1.030	1.002	0.999
1967	1.500	1.171	1.050	0.999	
1968	1.385	1.122	1.020		
1969	1.405	1.128			
1970	1.575				

The latest diagonal is revised to reflect the transfer of 50% of estimated IBNR as of 12/31/71 based on the original data (Exhibit 1) into case reserves

Exhibit 11b

After Reserve Strengthening

IBNR Reserve Calculation

(as of 12/31/71)

as a function of case incurred losses

Development Period	Three Year Data Beginning	Ending	Indicated LDFs	Age-to Ultimate LDFs
	(1)	(2)	Exhibit Strength 1	(4)
1st-2nd	$10,250	$14,897	1.453	1.705
2nd-3rd	12,925	14,692	1.137	1.173
3rd-4th	13,025	13,440	1.032	1.032
4th-Ult	8,290	8,295	1.000	1.000

4th-ultimate LDF is set at 1.00 (as if BF paper)

Accident Year	Case Incurred Losses as of 12/31/71	IBNR Factor	Revised Loss Method IBNR	Original Loss Method IBNR
	(5)	(6)=(4)-1	(7)=(5)x(6)	(8)
1971	$5,629	0.705	$3,967	$2,758
1970	5,197	0.173	899	$795
1969	5,867	0.032	187	$184
1968	5,150	0.000	0	$0
Total			**$5,053**	**$3,737**

(4) Based on (3)

(5) From Exhibit 11a

(7) After reserve strenghtening

Exhibit 11c

After Reserve Strengthening

Method 1:
IBNR Reserve Calculation

(as of 12/31/71)

as a function of expected losses

Development Period	Three Year Data Beginning	Three Year Data Ending	Selected LDFs	Age-to Ultimate LDFs
	(1)	(2)	(3)=(2)/(1)	(4)
1st-2nd	$10,250	$14,897	1.453	1.705
2nd-3rd	12,925	14,692	1.137	1.173
3rd-4th	13,025	13,440	1.032	1.032
4th-Ult	8,290	8,290	1.000	1.000

4th-ultimate LDF is set at 1.00 (as in BF paper)

Accident Year	Expected Losses	Expected Losses	Expected Losses IBNR factor	Revised IBNR	Original IBNR
	(5)	(6)=(5)x.95	(7)=1-[1/(4)]	(8)=(7) x (6)	(9)
1971	$8,000	$7,600	0.413	$3,142	$2,991
1970	7,500	7,125	0.147	1,050	$1,012
1969	7,000	6,650	0.031	205	$205
1968	6,000	5,700	0.000	0	$0
Total				$4,398	$4,208

(4) Based on (3)
(6) Based on an expected loss ratio = 95%
(9) From Exhibit 2

Exhibit 11d

After Reserve Strengthening

Case Incurred Losses including ALAE

($ 000's omitted)

Earned Premiums Net of Commission	Accident Year	Development First Report	Second Report	Third Report	Fourth Report	Fifth Report	Sixth Report
5,000	1966	2,500	3,650	4,200	4,325	4,335	*4,330*
5,500	1967	2,150	3,225	3,775	3,965	*3,960*	
6,000	1968	3,250	4,500	5,050	*5,150*		
7,000	1969	3,700	5,200	*5,867*			
7,500	1970	3,300	*5,197*				
8,000	1971	*5,629*					

Percent of Premium Age-to-Age Factors

Accident Year	1-2 Report	2-3 Report	3-4 Report	4-5 Report	5-6 Report
1966	0.230	0.110	0.025	0.002	-0.001
1967	0.195	0.100	0.035	-0.001	
1968	0.208	0.092	0.017		
1969	0.214	0.095			
1970	0.253				

Exhibit 11e

After Reserve Strengthening

Method 5: Percentage of Premium Method

Development Period	Most Recent Observation	First Prior Observation	Second Prior Observation	Selected Factor
	(1)	(2)	(3)	(4)
12 - 24	0.253	0.214	0.208	0.225
24 - 36	0.095	0.092	0.100	0.096
36 - 48	0.017	0.035	0.025	0.026
48 - 60	-0.001	0.002	0.000	0.000

Development Period	Percentage of Premium Method IBNR Factor	Accident Year	Earned Premium	Revised Estimated IBNR Required	Original Estimated IBNR Required
	(5)		(6)	(7)=(5)x(6)	(7)=(5)x(6)
12 to ult	0.346	1971	$8,000	$2,771	$2,595
24 to ult	0.121	1970	7,500	911	878
36 to ult	0.026	1969	7,000	180	180
48 to ult	0.000	1968	6,000	0	0
Total				$3,862	$3,652

(4) Simple average of (1), (2), (3)
(5) Upward additive accumulation of Column (4)
(6) From Exhibit 7

Exhibit 11: Summary

Summary Table: Impact of Case Reserve Strengthening

Method	Original IBNR Estimate	IBNR Estimate after case reserve strengthening	Difference	Percentage Change
	(1)	(2)	(3)=(2)-(1)	(4)=(3)/(1)
Loss Development	$3,737	$5,053	$1,316	35%
Percent of Premium	3,652	3,862	210	6%
Expected Loss/B-F	4,208	4,398	189	4%

Loss Development Method is most heavily impacted. Why?
Latest diagonal increases and loss development factors also increase.
The increased loss development factors are then applied to the already stregnthed diagonal of case incurred losses. Its a mess.

Please Note:
In a situation involving case reserve strengthening (with a consistent loss ratio) none of the methods produce accurate IBNR estimates. It becomes a question of which method is least wrong.

In a situation involving case reserve strengthening (with a deteriorating loss ratio) it is possible that either the percentage of premium or expected loss methods could produce an accurate IBNR estimate. This could occur if the impact of the case reserve strengthening was exactly offset by the impact of the loss ratio deterioration. This would be unlikely, however

Estimated IBNR Loss Emergence
Based on Method 1 and Method 2
(during Calendar Year 1972)

Method 1

Accident Year	Earned Premiums	Expected Lossess	Expected Losses IBNR factor	Estimated IBNR at 12/31/71	Estimated IBNR Emergence in CY 1972	Estimated IBNR at 12/31/72
	(1a)	(2a)=(1a)*0.95)	(3a)	(4a)=(2a)*(3a)	(5a)	(6a)=(4a)-(5a)
1971	$8,000	$7,600	0.394	$2,994	$1,911	$1,083
1970	7,500	7,125	0.142	1,012	792	220
1969	7,000	6,650	0.031	206	205	1
1968	6,000	5,700	0	0	0	0
Total				4,212	2,908	1,304

Method 2

Accident Year	Case Incurred Losses as of 12/31/71	IBNR Factor	Estimated IBNR at 12/31/71	Estimated IBNR Emergence in CY 1972	Estimated IBNR at 12/31/72
	(1b)	(2b)	(3b)=(1b)*(2b)	(4b)	(5b)=(3b)-(4b)
1971	$4,250	0.649	$2,758	$1,762	$996
1970	4,800	0.166	797	622	175
1969	5,775	0.032	185	184	1
1968	5,150	0	0	0	0
Total			3,740	2,568	1,172

All method 1 information from Exhibit 2
All method 2 information from Exhibit 3

EXHIBIT III

Exhibit III

Medical Malpractice Information

2002

Company Name	1 FL Med Mal Dir Prem Written	2 FL Med Mal Dir Pre Earned	3 FL Med Mal Dir Losses Incurred	4 FL Med Mal DCC Incurred	5 FL Med Mal Dir Losses Paid	6 FL Med Mal DCC Paid	7 FL Med Mal Loss Ratio(a)	8 FL Med Mal DCC Expense Ratio(b)	9 (a)+(b)	10 One Year Med Mal Reserve Development	11 Two Year Med Mal Reserve Development	12 Net Med Mal Bulk+IBNR Reserve	13 Net Med Mal Bulk+IBNR Reserve as % of Net Med Mal Reserves
First Professionals Ins Co	169,558,079	152,449,954	94,069,722	33,291,504	44,823,134	24,375,944	62%	22%	84%	1,590,000	9,224,000	(13,961,000)	-7%
Health Care Ind Inc	106,482,154	106,482,154	86,394,037	12,210,426	86,560,075	16,943,431	81%	11%	93%	(22,247,000)	(55,257,000)	528,037,000	42%
Pronational Ins Co	69,113,034	60,347,429	23,617,524	26,244,678	24,672,224	21,812,659	39%	43%	83%	(6,189,000)	22,875,000	145,105,000	29%
MAG Mut Ins Co	52,976,737	40,956,626	42,365,508	7,993,366	16,695,508	6,057,366	103%	20%	123%	20,460,000	(17,433,000)	489,000	0%
Truck Ins Exch	50,996,746	53,497,755	70,389,982	13,756,810	43,895,101	10,832,808	132%	26%	157%	4,251,000	4,109,000	12,455,000	43%

2001

Company Name	1 FL Med Mal Dir Prem Written	2 FL Med Mal Dir Pre Earned	3 FL Med Mal Dir Losses Incurred	4 FL Med Mal DCC Incurred	5 FL Med Mal Dir Losses Paid	6 FL Med Mal DCC Paid	7 FL Med Mal Loss Ratio(a)	8 FL Med Mal DCC Expense Ratio(b)	9 (a)+(b)	10 One Year Med Mal Reserve Development	11 Two Year Med Mal Reserve Development	12 Net Med Mal Bulk+IBNR Reserve	13 Net Med Mal Bulk+IBNR Reserve as % of Net Med Mal Reserves
First Professionals Ins Co	109,672,505	89,044,736	60,151,888	19,898,026	51,682,429	18,260,262	68%	22%	90%	9,990,000	11,590,000	(6,914,000)	-4%
Health Care Ind Inc	88,970,154	88,970,154	95,305,166	14,711,961	69,271,434	16,510,669	107%	17%	124%	(44,044,000)	(98,570,000)	502,113,000	43%
Pronational Ins Co	55,259,931	57,149,827	51,412,895	21,964,368	44,196,328	24,553,178	90%	38%	128%	26,321,000	7,580,000	147,046,000	32%
MAG Mut Ins Co	26,525,321	19,808,077	22,262,490	10,328,666	7,008,990	3,269,666	112%	52%	165%	(18,265,000)	(27,688,000)	7,972,000	3%
Truck Ins Exch	35,245,611	28,668,519	15,102,796	4,847,953	26,044,034	8,513,347	53%	17%	70%	884,000	(665,000)	10,381,000	49%

2000

Company Name	1 FL Med Mal Dir Prem Written	2 FL Med Mal Dir Pre Earned	3 FL Med Mal Dir Losses Incurred	4 FL Med Mal DCC Incurred	5 FL Med Mal Dir Losses Paid	6 FL Med Mal DCC Paid	7 FL Med Mal Loss Ratio(a)	8 FL Med Mal DCC Expense Ratio(b)	9 (a)+(b)	10 One Year Med Mal Reserve Development	11 Two Year Med Mal Reserve Development	12 Net Med Mal Bulk+IBNR Reserve	13 Net Med Mal Bulk+IBNR Reserve as % of Net Med Mal Reserves
First Professionals Ins Co	69,981,763	65,649,122	36,456,829	20,745,904	55,442,645	18,419,321	56%	32%	87%	6,275,000	(17,561,000)	(4,807,000)	-3%
Health Care Ind Inc	79,146,087	79,146,087	55,599,597	33,927,417	66,126,155	10,036,150	70%	43%	113%	(63,762,000)	(111,664,000)	489,345,000	43%
Pronational Ins Co	57,609,425	56,801,083	82,177,140	22,348,485	44,588,979	25,191,053	145%	39%	184%	(835,000)	(35,244,000)	101,003,000	25%
MAG Mut Ins Co	11,788,918	9,493,590	7,392,550	2,181,602	5,948,050	2,268,602	78%	23%	101%	(9,130,000)	(11,062,000)	6,233,000	3%
Truck Ins Exch	23,585,973	23,381,222	40,439,254	6,538,869	22,321,710	6,079,248	173%	28%	201%	(1,319,000)	(1,617,000)	8,653,000	49%

[illegible]

Company Name	FL Med Mal Dir Prem Written	FL Med Mal Dir Pre Earned	FL Med Mal Dir Losses Incurred	FL Med Mal DCC Incurred	FL Med Mal Dir Losses Paid	FL Med Mal DCC Paid	FL Med Mal Loss Ratio(a)	FL Med Mal DCC Expense Ratio(b)	(a)+(b)	One Year Med Mal Reserve Development	Two Year Med Mal Reserve Development	Net Med Mal Bulk+IBNR Reserve	Net Med Mal Bulk+IBNR Reserve as % of Net Med Mal Reserves
First Professionals Ins Co	70,073,897	70,853,737	30,410,053	6,371,060	44,545,569	15,846,050	43%	9%	52%	(20,662,000)	(34,803,000)	(17,361,000)	-11%
Health Care Ind Inc	74,707,458	74,707,458	61,986,675	17,450,859	63,310,996	11,268,167	83%	23%	106%	(58,792,000)	(130,015,000)	591,936,000	49%
Pronational Ins Co	57,114,420	56,442,471	10,419,812	59,120,289	53,592,494	26,972,159	18%	105%	123%	(24,026,000)	(20,462,000)	125,917,000	33%
MAG Mut Ins Co	6,612,025	8,121,409	10,123,100	3,252,570	2,100,100	1,625,570	125%	40%	165%	(1,866,000)	(12,677,000)	5,159,000	2%
Truck Ins Exch	12,885,174	15,432,591	31,141,555	7,322,781	15,240,694	3,443,608	202%	47%	249%	(318,000)	(5,147,000)	9,540,000	70%

Exhibit III

Medical Malpractice Information

[illegible]

Company Name	FL Med Mal Dir Prem Written	FL Med Mal Dir Pre Earned	FL Med Mal Dir Losses Incurred	FL Med Mal DCC Incurred	FL Med Mal Dir Losses Paid	FL Med Mal DCC Paid	FL Med Mal Loss Ratio(a)	FL Med Mal DCC Expense Ratio(b)	(a)+(b)	One Year Med Mal Reserve Development	Two Year Med Mal Reserve Development	Net Med Mal Bulk+IBNR Reserve	Net Med Mal Bulk+IBNR Reserve as % of Net Med Mal Reserves
First Professionals Ins Co	74,167,232	71,377,703	40,416,268	15,847,088	39,121,585	13,150,567	57%	22%	79%	(15,993,000)	(19,989,000)	11,460,000	6%
Health Care Ind Inc	69,555,050	69,555,050	39,646,272	12,865,255	31,574,756	6,604,938	57%	18%	75%	(68,721,000)	(113,394,000)	644,119,000	53%
Pronational Ins Co	44,625,771	58,640,452	77,950,253	25,990,603	53,343,482	28,602,755	133%	44%	177%	2,475,000	(30,860,000)	151,122,000	38%
MAG Mut Ins Co	4,692,470	4,684,634	1,384,500	1,001,008	582,500	568,288	30%	21%	51%	(8,582,000)	(21,723,000)	4,239,000	2%
Truck Ins Exch	11,579,255	10,761,064	23,640,669	4,655,597	12,789,781	3,028,016	220%	43%	263%	(4,827,000)	(5,449,000)	4,903,000	78%

1997

Company Name	1 FL Med Mal Dir Prem Written	2 FL Med Mal Dir Pre Earned	3 FL Med Mal Dir Losses Incurred	4 FL Med Mal DCC Incurred	5 FL Med Mal Dir Losses Paid	6 FL Med Mal DCC Paid	7 FL Med Mal Loss Ratio(a)	8 FL Med Mal DCC Expense Ratio(b)	9 (a)+(b)	10 One Year Med Mal Reserve Development	11 Two Year Med Mal Reserve Development	12 Net Med Mal Bulk+IBNR Reserve	13 Net Med Mal Bulk+IBNR Reserve as % of Net Med Mal Reserves
First Professionals Ins Co	72,338,052	69,254,477	53,868,826	14,629,202	30,409,049	11,240,942	78%	21%	99%	(5,762,000)	(21,868,000)	28,628,000	12%
Health Care Ind Inc	67,720,684	67,720,684	40,486,290	22,115,047	43,413,955	9,124,594	60%	33%	92%	(116,963,000)	(101,752,000)	628,954,000	59%
Pronational Ins Co							-	-	-			94,828,000	52%
MAG Mut Ins Co	3,427,567	3,792,065	2,658,800	1,059,186	140,000	509,440	70%	28%	98%	(10,969,000)	(22,831,000)	4,140,000	2%
Truck Ins Exch	9,561,917	4,507,522	7,966,633	1,259,061	11,189,811	4,523,406	177%	28%	205%	(622,000)	(1,055,000)	10,383,000	81%

[illegible]

Company Name	FL Med Mal Dir Prem Written	FL Med Mal Dir Pre Earned	FL Med Mal Dir Losses Incurred	FL Med Mal DCC Incurred	FL Med Mal Dir Losses Paid	FL Med Mal DCC Paid	FL Med Mal Loss Ratio(a)	FL Med Mal DCC Expense Ratio(b)	(a)+(b)	One Year Med Mal Reserve Development	Two Year Med Mal Reserve Development	Net Med Mal Bulk+IBNR Reserve	Net Med Mal Bulk+IBNR Reserve as % of Net Med Mal Reserves
First Professionals Ins Co	62,857,424	60,455,567	41,104,510	6,152,788	30,907,510	9,132,788	68%	10%	78%	(12,734,000)	(27,763,000)	36,690,000	25%
Health Care Ind Inc	59,266,041	59,266,041	63,010,993	20,692,241	33,910,664	8,006,431	106%	35%	141%	(12,993,000)	(5,966,000)	583,929,000	62%
Pronational Ins Co							-	-	-			94,244,000	56%
MAG Mut Ins Co	2,630,808	1,899,916	1,234,950	270,525	99,750	105,572	65%	14%	79%	(10,810,000)	(23,290,000)	3,624,000	2%
Truck Ins Exch	8,412,561	7,849,235	6,603,164	2,883,621	7,831,114	3,321,824	84%	37%	121%	(433,000)	(3,747,000)	12,482,000	77%

[illegible]

Company Name	FL Med Mal Dir Prem Written	FL Med Mal Dir Pre Earned	FL Med Mal Dir Losses Incurred	FL Med Mal DCC Incurred	FL Med Mal Dir Losses Paid	FL Med Mal DCC Paid	FL Med Mal Loss Ratio(a)	FL Med Mal DCC Expense Ratio(b)	(a)+(b)	One Year Med Mal Reserve Development	Two Year Med Mal Reserve Development	Net Med Mal Bulk+IBNR Reserve	Net Med Mal Bulk+IBNR Reserve as % of Net Med Mal Reserves
First Professionals Ins Co	55,544,090	53,906,107	32,042,228	11,154,211	25,930,228	8,569,211	59%	21%	80%	(13,177,000)	(27,099,000)	47,753,000	34%
Health Care Ind Inc	72,218,469	72,218,469	62,989,227	19,314,236	19,972,603	5,613,988	87%	27%	114%	(7,336,000)	(58,429,000)	505,432,000	64%
Pronational Ins Co							-	-	-			97,082,000	58%
MAG Mut Ins Co	1,563,122	1,058,408	975,000	195,859	-	36,934	92%	19%	111%	(10,761,000)	(18,205,000)	4,052,000	2%
Truck Ins Exch	7,556,446	7,652,451	7,687,546	2,182,092	4,933,883	2,672,893	100%	29%	129%	(3,314,000)	(12,501,000)	14,467,000	69%

Exhibit III

Medical Malpractice Information

	1	2	3	4	5	6	7	8	9	10	11	12	13
Company Name	FL Med Mal Dir Prem Written	FL Med Mal Dir Pre Earned	FL Med Mal Dir Losses Incurred	FL Med Mal DCC Incurred	FL Med Mal Dir Losses Paid	FL Med Mal DCC Paid	FL Med Mal Loss Ratio(a)	FLMed Mal DCC Expense Ratio(b)	(a) + (b)	One Year Med Mal Reserve Development	Two Year Med Mal Reserve Development	Net Med Mal Bulk+IBNR Reserve	Net Med Mal Bulk+IBNR Reserve as % of Net Med Mal Reserves
First Professionals Ins Co	51,516,127	51,271,014	25,406,987	12,905,118	17,118,987	7,669,118	50%	25%	75%	(11,953,000)	(37,708,000)	41,690,000	38%
Health Care Ind Inc	75,958,090	75,958,090	68,159,600	17,553,206	12,820,731	3,698,299	90%	23%	113%	(146,602,000)	(157,379,000)	354,549,000	64%
Prossional Ins Co							-	-	-			164,061,000	59%
MAG Mut Ins Co	6,076	253	-	-	-	-	0%	0%	0%	(7,868,000)	(15,836,000)	3,667,000	2%
Truck Ins Exch	6,595,010	6,498,675	8,299,308	4,482,769	4,422,242	2,329,748	128%	75%	203%	(9,187,000)	(9,888,000)	21,076,000	67%

1993

	1	2	3	4	5	6	7	8	9	10	11	12	13
Company Name	FL Med Mal Dir Prem Written	FL Med Mal Dir Pre Earned	FL Med Mal Dir Losses Incurred	FL Med Mal DCC Incurred	FL Med Mal Dir Losses Paid	FL Med Mal DCC Paid	FL Med Mal Loss Ratio(a)	FL Med Mal DCC Expense Ratio(b)	(a) +(b)	One Year Med Mal Reserve Development	Two Year Med Mal Reserve Development	Net Med Mal Bulk+IBNR Reserve	Net Med Mal Bulk+IBNR Reserves as % of Net Med Mal Reserves
First Professionals Ins Co	50,741,144	47,036,669	20,645,105	1,663,148	20,061,605	7,328,148	44%	4%	47%	(27,613,002)	(36,808,000)	40,817,000	34%
Health Care Ind Inc	11,322,020	10,351,978	13,496,378	5,373,757	8,333,914	4,048,383	70%	28%	98%	3,888,000	2,777,000	192,466,000	57%
Prossional Ins Co							-	-	-			119,684,000	60%
MAG Mut Ins Co							-	-	-			3,108,000	2%
Truck Ins Exch	5,678,284	5,501,632	8,128,657	4,919,378	2,426,870	818,918	148%	89%	237%	(701,000)	(7,368,000)	37,264,000	70%

8/4/2003
Source: NAIC Database

EXHIBIT IV

Exhibit IV

Licensed Insurers Reporting Prior Medical Malpractice Premiums in Florida

ACE AMERICAN INSURANCE COMPANY
ACE FIRE UNDERWRITERS INSURANCE COMPANY
ACE PROPERTY AND CASUALTY INSURANCE COMPANY
AMERICAN CASUALTY COMPANY OF READING, PENNSYLVANIA
AMERICAN GUARANTEE AND LIABILITY INSURANCE COMPANY
AMERICAN HEALTHCARE INDEMNITY COMPANY
AMERICAN HOME ASSURANCE COMPANY
AMERICAN INSURANCE COMPANY (THE)
AMERICAN STATES INSURANCE COMPANY
ANESTHESIOLOGISTS PROFESSIONAL ASSURANCE COMPANY
ATHENA ASSURANCE COMPANY
BANKERS STANDARD INSURANCE COMPANY
CENTURY INDEMNITY COMPANY
CHURCH MUTUAL INSURANCE COMPANY
CINCINNATI INSURANCE COMPANY
CLARENDON NATIONAL INSURANCE COMPANY
COLONY NATIONAL INSURANCE COMPANY
CONNECTICUT INDEMNITY COMPANY
CONTINENTAL CASUALTY COMPANY
CONTINENTAL INSURANCE COMPANY
DOCTORS' COMPANY, AN INTERINSURANCE EXCHANGE (THE)
FIDELITY AND CASUALTY COMPANY OF NEW YORK
FIREMAN'S FUND INSURANCE COMPANY
FIRST PROFESSIONALS INSURANCE COMPANY, INC
FLORIDA MEDICAL MALPRACTICE JOINT UNDERWRITING ASSOCIATION
GENERAL INSURANCE COMPANY OF AMERICA
GENESIS INSURANCE COMPANY
GLENS FALLS INSURANCE COMPANY
GRANITE STATE INSURANCE COMPANY
GULF INSURANCE COMPANY
HARBOR SPECIALTY INSURANCE COMPANY
HEALTH CARE INDEMNITY, INC.
ILLINOIS NATIONAL INSURANCE COMPANY
INSURANCE COMPANY OF NORTH AMERICA
INSURANCE COMPANY OF THE STATE OF PENNSYLVANIA
KANSAS CITY FIRE AND MARINE INSURANCE COMPANY
KEMPER CASUALTY INSURANCE COMPANY
LIBERTY MUTUAL INSURANCE COMPANY
LION INSURANCE COMPANY
LUMBERMENS MUTUAL CASUALTY COMPANY
MAG MUTUAL INSURANCE COMPANY
NATIONAL FIRE INSURANCE COMPANY OF HARTFORD
NATIONAL SURETY CORPORATION
NATIONAL UNION FIRE INSURANCE CO. OF PITTSBURG, PA
NATIONWIDE MUTUAL FIRE INSURANCE COMPANY
NATIONWIDE MUTUAL INSURANCE COMPANY
NATIONWIDE PROPERTY AND CASUALTY INSURANCE COMPANY
ODYSSEY AMERICA REINSURANCE CORPORATION
ONEBEACON INSURANCE COMPANY
PACIFIC EMPLOYERS INSURANCE COMPANY
PENNSYLVANIA GENERAL INSURANCE COMPANY
SOUTH FLORIDA DENTIST
SOUTH FLORIDA OPHTHAMOLOGIST
SOUTH PINELLAS MEDICAL TRUST
SOUTH FLORIDA PHYSICIANS
ST. PAUL FIRE & MARINE INSURANCE COMPANY
ST. PAUL GUARDIAN INSURANCE COMPANY
ST. PAUL MERCURY INSURANCE COMPANY
TIG INDEMNITY COMPANY
TIG INSURANCE COMPANY
TRANSPORTATION INSURANCE COMPANY
TRAVELERS INDEMNITY COMPANY
TRAVELERS INDEMNITY COMPANY OF AMERICA
TRAVELERS INDEMNITY COMPANY OF ILLINOIS
TRUCK INSURANCE EXCHANGE
VALIANT INSURANCE COMPANY
VALLEY FORGE INSURANCE COMPANY
WESTPORT INSURANCE CORPORATION
ZURICH AMERICAN INSURANCE COMPANY

8/5/2003
Source: NAIC Database

f. Please provide a report that reconciles the reserve assigned to each claim and the actual amount paid on each claim, both for settlement or judgment amounts and for loss adjustment expenses, as well as claim reserves that never resulted in a claim being brought.

2. Regarding Market Activity:

a. Did a Vermont based risk retention group recently obtain authority to write insurance in Florida? When was this company authorized and is it currently issuing policies in Florida? Are there any other similar groups of any type, mutuals, trusts, or risk retention groups, applying to offer coverage in Florida?

3. Regarding Reserve Audits:

a. Please provide a table indicating whether the 5 largest writers of medical malpractice insurance in Florida over the last 10 years, as demonstrated by those carriers market share percentage, have been overestimating or underestimating their reserves.

b. If such information is unavailable, please provide draft legislation that would assist the Office of Insurance Regulation in getting this information.

4. Regarding Closed-Claim Reporting:

a. Please identify all of the entities and individuals who have to report closed claims to the Office of Insurance Regulation.

b. Please identify all of the entities and individuals who have failed to report closed claims to the Office of Insurance Regulation in each of the last five years.

c. What percentage of claims are not being reported due to an entity or individual not being required to report?

5. Regarding Paid Losses vs. Expenses:

a. Please provide a breakdown for each of the 5 largest carriers, as demonstrated by those carriers market share percentage, of the total amount of losses paid and the total amount that went to loss adjustment expenses for each of the last five years.

b. Is there a factor added to the loss adjustment expenses that is attributable to general overhead?

c. How does the ratio of losses paid vs. adjustment expense today compare with the ratio during similar events impacting the availability of professional medical liability insurance in 1975 and 1986-87?

d. Have administrative costs and expense adjustment costs increased or decreased over the five years?

6. Regarding Accounting Practices:

a. The committee asked for the Office of Insurance Regulation's opinion of FPIC's one-time loss of $29,578,000, taken in 2002. Why was that permitted and how does it impact the bottom line of

FPIC and is this reported loss a factor in the rate increases FPIC submitted and received in 2001 totaling 40.4% and in 2002 for 21.1%?

We ask that you please provide the appropriate responsive documentation to the Senate Committee on Judiciary no later than **5:00 pm on Monday, August 4, 2003**. To aid you in your response, we have attached those pages of the transcript that contain your testimony. If you have any questions, please contact Judiciary Committee staff at (850) 487-5198.

Sincerely,

Senator Alex Villalobos
Chair

ROBERTS.DAWN

From: Steve Roddenberry [RoddenberryS@dfs.state.fl.us]
Sent: Monday, August 04, 2003 7:40 PM
To: VILLALOBOS.ALEX.WEB
Cc: roberts.dawn@flsenate.gov; GREENBAUM.DAVID; Kimberly Case; Bill Warren; Kevin McCarty; Lee Roddenberry; Cynthia Fuller; Shirley Kerns
Subject: Response to July 29, 2003, Letter

Chairman Villalobos:

Attached please find an electronic copy of the response you requested in your letter dated July 29, 2003. Your letter, which was received on July 31, 2003, requested that the Office of Insurance Regulation respond by 5:00 pm today. The attached constitutes the Office's best efforts to respond in the timeframe allowed. Several questions remain outstanding. Answers will be provided as soon as the information is compiled. A hard copy of the Office's response and the attachments referenced therein will be remitted tomorrow.

DEPARTMENT OF FINANCIAL SERVICES
OFFICE OF INSURANCE REGULATION

KEVIN M. MCCARTY
DIRECTOR

FINANCIAL SERVICES COMMISSION
JEB BUSH
GOVERNOR
TOM GALLAGHER
CHIEF FINANCIAL OFFICER
CHARLIE CRIST
ATTORNEY GENERAL
CHARLES BRONSON
COMMISSIONER OF AGRICULTURE

August 4, 2003

Honorable J. Alex Villalobos
Room 305 Senate Office Building
404 South Monroe Street
Tallahassee, FL 32399-1100

Dear Senator Villalobos:

Your letter dated July 29, 2003, was received, via Federal Express, on July 31, 2003. The Office of Insurance Regulation (Office) intends to respond to each question. Some of the answers, however, are included, at least in part, in a letter sent to your office on July 31, 2003. The answers to some of the questions in your recent letter may not be readily available as they regard the unique practices of insurers. The standards for many of these practices are not established in the Insurance Code.

The following responses are in the order of the questions initially posed.

1. Regarding Reserves:

a. The criterion for when a claim should be opened is not established in the Insurance Code. Companies may use criterion that is consistent with how they recognize and ultimately adjudicate claims. However, most insurers will recognize and open a claim when a demand by an individual or corporation is received to recover under a policy of insurance a loss which may come within that policy. Section 766.106(2), Florida Statutes, addresses some of the procedures that a person must follow prior to filing a medical malpractice claim. Under Chapter 4-166.021(8), Florida Administrative Code, "Notification of a claim" is defined as any notice to an insurer or its agent by a claimant or an insured that reasonably apprises the insurer that a loss has occurred. Pursuant to Subsection (9) of this same Chapter, "Notice of loss" means: a written notice, such as claim forms, medical bills, medical authorizations or other reasonable evidence of the claim that is ordinarily required of a claimant; or any notice by or on behalf of a claimant that reasonably apprises the insurer that a loss has occurred and that the claimant wishes to make a claim under an insurance policy or against a person insured under an insurance policy for such loss. Section 766.106(3), Florida Statutes,

J. STEVE RODDENBERRY • DEPUTY DIRECTOR • OFFICE OF INSURANCE REGULATION
200 EAST GAINES STREET • TALLAHASSEE, FLORIDA 32399-0326 • (850) 413-5104 • FAX (850) 488-2348

establishes the responsibility of the insurer in its timely review of the medical malpractice claim.

b. i-iii. The response to each of these scenarios may be different for each insurer. The Insurance Code does not specify the circumstances under which a claim may be opened and a reserve established thereon. However, in light of the guidance provided in the above mentioned statutes and rules, it is extremely likely that a claim will be opened in scenarios 1.b.i and 1.b.iii, referenced in your letter.

c. On page 14, line 7, the transcript reports my use of the word "triangle". While phonetically similar, the word that I actually used was *triennial*. I would like to elaborate further on my testimony. The triennial financial examinations of our domestic insurers will include a reserve analysis. The Office requests that the companies being examined provide individual claims information. Once this information is received from the company, the Office's actuarial staff will extrapolate the data and summarize the information into accident years, which is consistent with the Schedule P format as established in the National Association of Insurance Commissioners (NAIC) annual financial statement. It is then necessary to make sure this summarized data reconciles with that which is actually stated in the annual financial statement. If the data does not appear to reconcile, then further detail must be provided by the company to establish where the differences lie. Additionally, the company's opining actuary is required to reconcile the data he/she uses for their actuarial analysis in and to Schedule P. This is a requirement which is stated in the development of their actuarial opinion. Since this information is requested every three years, the data will not be available for the five year period as requested. Attached as Exhibit I is a copy of the Financial Examination of ProNational Insurance Company by its domestic regulator, the State of Michigan. The independent actuary hired by the examination team concludes, among other things, that the Company's reserves make a reasonable provision for all unpaid loss and loss expense obligations of the Company under the terms of its policies and agreements. Also included as Exhibit I is a copy of the Office's reconciliation of the reserving data for First Professionals Insurance Company (FPIC). This document summarizes the Office's analysis of the raw claim data provided by FPIC. In a sealed envelope accompanying this response is the actual raw claim data. This particular information is confidential pursuant to Section 624.319(3)(b), Florida Statutes, and exempt from Section 119.07(1), Florida Statutes. It is provided pursuant to an exemption in Section 624.319(3)(b), Florida Statutes, which states in pertinent part, "Such confidential and exempt information may be disclosed to another governmental entity, if disclosure is necessary for the receiving entity to perform its duties and responsibilities . . . . The receiving governmental entity or the association must maintain the confidential and exempt status of the information."

d. The criterion for setting reserves on IBNR claims is not established in the Insurance Code. Each insurer establishes this criterion. For the most part, medical malpractice carriers sell claims-made policies. By their nature, claims-made policies do not necessitate much in the way of incurred but not reported (IBNR) reserves. For all other lines of insurance, there are various techniques used to estimate the IBNR reserve. Attached are examples of some of the methods that are accepted by the Casualty Actuarial Society. These are only a selected number of techniques and other methods are available. When estimating the IBNR reserve, the opining actuary must use judgment to determine which method is appropriate. Please see Exhibit II.

e. As noted above, claims-made policies do not typically warrant a large volume of IBNR reserves. The National Association of Insurance Commissioners (NAIC), of which Office is a member, has developed a format for reporting the financial condition of insurers. This format is used nationwide for reporting financial information to insurance regulators. These financial statements do not distinguish IBNR from the bulk reserves. Bulk reserves are established to fund inadequate case reserves or provide an account for excess case reserves. See Exhibit III, Columns 12 and 13.

f. This is not information that is in the possession of the Office.

2. Regarding Market Activity

a. Physicians Professional Liability RRG is a Vermont-domiciled risk retention group that received approval from the Office on April 11, 2003, to begin providing medical malpractice coverage. This entity is currently transacting business in Florida.

There is one pending application for registration for an Arizona domiciled RRG. The name of the entity is Applied Medico-Legal Solutions RRG.

3. Regarding Reserve Audits

a. Schedule P from the annual financial statement provides a summary of reserves and reserve development for all years from the company's inception to date (cumulative). Positive amounts indicate reserves were too low. Negative amounts indicate reserves were too high. See Exhibit III. For the one year development of the reserves since the company's inception, see Column 10. For the two year development of the reserves since the company's inception, See Column 11.

b. N/A

4. Regarding Closed Claim Reporting:

a. The entities required to report closed claims to the Office are specified in Section 627.912, FS. The relevant portions are provided below:

627.912 Professional liability claims and actions; reports by insurers.—
(1) Each self-insurer authorized under ss. 627.357 and each insurer or joint underwriting association providing professional liability insurance to a practitioner of medicine licensed under chapter 458, to a practitioner of osteopathic medicine licensed under chapter 459, to a podiatric physician licensed under chapter 461, to a dentist licensed under chapter 466, to a hospital licensed under chapter 395, to a crisis stabilization unit licensed under part IV of chapter 394, to a health maintenance organization certificated under part I of chapter 641, to clinics included in chapter 390, to an ambulatory surgical center as defined in ss. 395.002, or to a member of The Florida Bar shall report in duplicate to the Department of Insurance any claim or action for damages for personal injuries claimed to have been caused by error, omission, or negligence in the performance of such insured's professional services or based on a claimed performance of professional services without consent, ...

A list of the companies with written premium at some point in the last ten years, and which currently have an active license is attached as Exhibit IV. Please be advised, however, that any of the entities referenced in Section 627.912, FS, that close a medical malpractice claim are required to report such claim to the Office, irrespective of the existence or amount of direct written premium in the year the claim is closed.

b. Entities that fail to report claims to the closed claim database do not report such omissions to the Office. The Office has not completed the development of a process to identify entities that fail to report closed claims to the Office.

c. We could not know what closed claims are not being reported by entities and individuals that are not required to report. We would not know if the underwriting of non-Florida domiciled risk retention groups is comparable to that of admitted insurers. Likewise, we would not know if the underwriting of surplus lines companies is consistent with admitted companies. This information would be critical to estimating what percentage of closed claims is not being reported by those two types of entities. We do know that surplus lines carriers wrote approximately 15 percent of 2002's direct written premium. We also know that risk retention groups wrote about two percent of the 2002 direct written premium. But for the reasons

stated previously, it would be inaccurate to expect these entities to report closed claims at a level commensurate with their respective direct written premium.

5. Regarding Paid Losses vs. Expenses

a. Please see the attached Exhibit III, Columns 5 and 6.

b. Allocated loss adjustment expenses (ALAE) are those expenses that can be directly attributed to a particular claim. Unallocated loss adjustment expenses (ULAE) are claim-related expenses and other expenses that are not attributable to the adjudication of a particular claim. This question can best be answered with providing definitions of loss adjustment expenses.

Loss Adjustment Expenses (LAE) = Allocated Loss Adjusted Expenses (ALAE) + Unallocated Loss Adjustment Expenses (ULAE)

ALAE is defined in the 1998 NAIC Accounting Practices & Procedures Manual as:

- Surveillance expenses.
- Medical cost containment expenses.
- Litigation management expenses.
- LAE for participation in voluntary/involuntary market pools if reported by accident year.
- Fees or salaries for appraisers, private investigators, hearing representatives, re-inspectors and fraud investigators, and rehabilitation nurses.

All ULAE (which now includes claim adjusters) must be assigned to one of 5 expense groups:

- Loss adjustment expenses.
- Acquisition, field supervision, and collection expenses.
- General expenses.
- Taxes, licenses, and fees.
- Investment expenses.

NAIC introduced new reporting requirements for loss adjustment expenses that became effective 1/1/1998. ALAE were deemed by the NAIC to mean expenses, whether internal or external to the company, related to defense, litigation and medical cost containment. ULAE are considered to be all loss expenses not specifically defined as ALAE. All adjuster fees are considered ULAE. Effective with the 1999 Annual Statement, the NAIC changed the titles of these expenses to match the revised

definitions. ALAE became "Defense and Cost Containment" expenses and ULAE became "Adjusting and Other" expenses.

c. The response to this question is under development and will take more time to complete.

d. Yes. To determine if the administrative costs and loss adjustment expenses have increased relative to total losses over the past five years will take some additional research and time.

6. Regarding Accounting Practices

The Office has reviewed the 2002 financial statement of FPIC, the insurance company. This statement reflects net income of $10,961,261, a net underwriting loss of ($6,892,800), and net investment gains of $18,632,979.

It would appear the ($29,578,000) figure referenced within question #6 was extracted from the financial statement of FPIC Insurance Group, a publicly traded company. This holding company owns numerous entities, not all of which transact insurance.

On page 21 of my testimony, reference is made by a committee member to FPIC's 2002 Income Statement reflecting total revenues of $220,865,000, total expenses of $197,155,000 and net losses **or** loss adjustment expenses of $139,571,000.

1) This information is apparently extracted from a financial statement of FPIC Insurance Group, Inc. The Office of Insurance Regulation is responsible for the regulation of FPIC, not the Group.
2) Further, the interpretation of the $139,571,000 expense is incorrect, as the definition of the amount is stated in the Income Statement to be: "Net losses **and** loss adjustment expenses". The key word being "and". Therefore, the summation that this insurance group was paying out approximately $140 million toward loss adjustment expenses and approximately $60 million toward losses is inaccurate.

Thank you for allowing the Office an opportunity to respond. Several of the inquiries will require additional time to develop comprehensive answers. We are working on those answers now and will respond as soon as possible.

It is clear that more information would assist in developing a solution should Florida be faced with another medical malpractice situation sometime in the future. Although we are confident that the resolution that is ultimately adopted will avert another dilemma, we are

anxious to begin compiling whatever additional data may help in the event policymakers want more information if there is a "next time". If not in this Special Session, perhaps in preparation for the 2004 Session, we can work with your staff in drafting legislation that will codify the desired information and authorize the Office to collect it. Please let me know if you would like the Office to work with your staff on developing the additional information that may be helpful in the future.

Sincerely,

J. Steve Roddenberry

JSR:rsr

Attachments

cc: Kevin McCarty, Director, Office of Insurance Regulation

Scott

THE FLORIDA SENATE

COMMITTEE ON JUDICIARY

Location
515 Knott Building
Mailing Address
404 South Monroe Street
Tallahassee, Florida 32399-1100
(850) 487-5198
J. Alex Villalobos, *Chair*
Dave Aronberg, *Vice Chair*
Dawn Roberts, *Staff Director*
Senate's Website: *www.flsenate.gov*

July 29, 2003

Jeff Scott
Associate General Counsel
Florida Medical Association
113 East College Ave.
Tallahassee, FL 32301

Dear Ms. Mortham and Mr. Scott:

In reviewing the transcript of the Senate Committee on Judiciary meeting on July 14-15, 2003, we have identified several occurrences where you were asked to provide information subsequent to your testimony. Additionally, the committee has identified certain issues for which it requests additional information. Specifically, we request a response in the following instances:

1. How many Florida licensed physicians are members of the Florida Medical Association (FMA)?
2. How many physicians ceased the practice of medicine in Florida last year? During the last 5 years? Please produce any records in support of the figures you provide in your answer.
3. What are the insurance premiums available to specialists in Miami-Dade for $250,000 policies? What about for $500,000 policies? Please include obstetricians, radiologists, neurologists, orthopedic surgeons, and emergency room physicians.
4. Please provide an exact incident(s) of a particular patient that has been denied access to care. Please provide any documentation in support of this allegation.
5. How many cases exist in Florida wherein you believe the expert witness provided testimony which is a gross misrepresentation of the standard of care? Please produce any documentation in support of any allegation
6. Please identify those expert witnesses that you characterized as "hired guns."
7. How much would it cost for a defendant to participate in the proposed presuit screening panels? What are those costs attributable to? What is the basis for your calculations?
8. How many notices of intent to litigate did FMA members receive last year? How many of those claims for which a notice of intent to litigate was received resulted in a lawsuit? How many of those claims for which a notice of intent to litigate was received resulted in settlements? How many of those claims for which a notice of intent to litigate was received went to trial? How many of those claims for which a notice of intent to litigate

was received were dismissed? How many of those claims for which a notice of intent to litigate was received resulted in indemnities paid by an insurer on behalf of the physician or paid by the physician? Please provide same for each of the last 5 years.

9. How many non-meritorious lawsuits were filed against FMA members last year? How many non-meritorious lawsuits were filed against FMA members during the each of the last 5 years? 10 years? Please explain how you determined that each lawsuit included in your count was non-meritorious.
10. Please produce a copy of the contract or any other written agreements between the FMA and First Professional Insurance Company (FPIC) that were in effect for any period of time during the last 3 years.
11. Please explain the process that has been used for the last 5 years to place FMA members on the FPIC board and the role that FPIC or its officers or directors play at the FMA. Please explain all benefits provided to these persons, including any direct or indirect remuneration, goods, services, or other benefits provided.

We ask that you please provide the appropriate responsive documentation to the Senate Committee on Judiciary no later than **5:00 pm on Monday, August 4, 2003**. We recognize that Ms. Mortham has already provided an affidavit to the committee that may in part answer these questions. If this is the case, please indicate so in your response. To aid you in your response, we have attached those pages of the transcript that contain your testimony. If you have any questions, please contact Judiciary Committee staff at (850) 487-5198.

Sincerely,

Senator Alex Villalobos
Chair

FLORIDA MEDICAL ASSOCIATION, INC.
P.O. Box 10269 • Tallahassee, Florida • 32302 • 113 E. College Ave. • 32301
(850) 224-6496 • (850) 222-8827-FAX • Internet Address: www.fmaonline.org

August 4, 2003

The Honorable J. Alex Villalobos
Chairman, Senate Judiciary Committee
515 Knott Building
Tallahassee, Florida 32399

Dear Senator Villalobos:

I am in receipt of your letter to Sandra Mortham and Jeff Scott, dated July 29, 2003 in which you ask a number of follow up questions to the carefully controlled, limited testimony you orchestrated at the behest of the trial bar on July 14, 2003. I have taken it upon myself to personally reply on behalf of the 16,328 members of the Florida Medical Association. Your questions ask for a tremendous amount of data. Unfortunately, the FMA does not have the resources to fully respond by your imposed due date. We do, however, assure you that the Judiciary Committee's attempt to call into question the existence of an access to care crisis are misguided and represent a tremendous disservice to the citizens of Florida. If you had attended the meetings of the Governor's Select Task Force or the House Select Committee on Medical Liability Insurance, you would have seen first hand the evidence of the impact this crisis has had on access to care. We invite you to review the reports of both groups for information concerning physicians who have left the state and/or scaled back their practices. In addition, you have the results of a survey we conducted in December of 2002 that elicited over 2,500 responses from physicians who have been impacted by the crisis. Furthermore, we are certain you have received numerous letters, emails and other communications from physicians indicating the seriousness of the crisis.

Since you have recently decided to place a premium on testimony given under oath, we present to you over 1,500 affidavits from physicians licensed in Florida who have attested to either having to quit the practice of medicine or having to scale back their practice due to liability concerns. These affidavits constitute sworn testimony that there are at least fifteen hundred physicians who are no longer providing the same level of care as they were before this crisis began. To say patient access to care has not been affected is to engage in intellectual dishonesty. Statistics can be spun many ways. As Chairman of the Judiciary Committee, we urge you not to hide behind misleading numbers and ignore the evidence of the crisis that does exist.

Sincerely,

Robert E. Cline, M.D.
President
Florida Medical Association

Thrasher

THE FLORIDA SENATE
COMMITTEE ON JUDICIARY

Location
515 Knott Building
Mailing Address
404 South Monroe Street
Tallahassee, Florida 32399-1100
(850) 487-5198

July 29, 2003

John Thrasher
Smith, Hulsey & Busey
225 Water St.
18th Floor
Jacksonville, FL 32202

Dear Mr. Thrasher:

In reviewing the transcript of the Senate Committee on Judiciary meeting on July 14-15, 2003, we have identified several occurrences where you were asked to provide information subsequent to your testimony. Additionally, the committee has identified certain issues for which it requests additional information. Specifically, we request a response in the following instances:

1. What evidence exists that there are an increasing number of claims against hospitals? Please explain.
2. How many notices of intent to litigate did hospitals receive last year? How many of those resulted in lawsuits? How many of those resulted in settlements? How many of those went to trial? How many were dismissed? How many resulted in indemnities paid by an insurer on behalf of the hospital or paid by the hospital? Please provide same for each of the last 5 years.
3. What are the premiums for professional liability insurance for hospitals in California?
4. What are the premiums for professional liability insurance for hospitals in Florida?

We ask that you please provide the appropriate responsive documentation to the Senate Committee on Judiciary no later than **5:00 pm on Monday, August 4, 2003.** To aid you in your response, we have attached those pages of the transcript that contain your testimony. If you have any questions, please contact Judiciary Committee staff at (850) 487-5198.

Sincerely,

Senator Alex Villalobos
Chair

FLORIDA HOSPITAL ASSOCIATION
An Association of Hospitals & Health Systems

August 11, 2003

Senator J. Alex Villalobos
Committee on Judiciary
515 Knott Building
Tallahassee, Florida

Dear Senator Villalobos:

Please allow this letter to serve as the Florida Hospital Association's response to the letter dated July 29, 2003 directed to John Thrasher, seeking additional information. We regret that much of the information you have requested is not available in a form that would allow us to provide a response to each of the questions in the short time frame allotted. However, we submit the following for the Committee's consideration:

1. We would refer you to the already submitted Milliman report, dated November 7, 2002, which analyzed all available data on Florida. In addition, we would refer you to the testimony and evidence submitted to the Governor's Select Task Force, as well as the testimony and evidence submitted to the House Select Committee. We also suggest the U.S. Congress Joint Economic Committee study released on May 6, 2003, the GAO report dated June 2003, and the U.S. HHS study released July 7, 2003.

Milliman is a respected actuary used by the State of Florida for its pension fund, and by the Florida Medical Malpractice JUA for its rate making. The Milliman report concluded that the frequency of claims per physician in Florida is approximately 36% above the US average. We are not aware of any data which would support a conclusion that the frequency of claims against hospitals differs in any material degree from the average.

We also wish to point out that certain studies which have been relied upon by others in this debate to suggest that payout on claims have not increased have *excluded* claims against hospitals. In as much as many physicians carry only $250,000 in liability insurance coverage, if they are insured at all, the results of such studies do not accurately reflect a complete picture of claims and settlements in Florida. The total payout of claims is much higher when payments by hospitals are considered.

2. The Florida Hospital Association does not track the number of notices of intent to initiate medical malpractice litigation filed against hospitals. This information

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cannot be collected and compiled within the short time frame within which we have been given to work.

3. and 4. The Florida Hospital Association conducted a survey of hospitals last year and, for those reporting, the premiums for medical malpractice liability insurance increased an average of 140% between 1999 and 2001. The Milliman report concluded that Florida physician losses and premiums were 50% above the national average, and that California physician losses and premiums were 50% below the national average. Otherwise, the Florida Hospital Association does not have at this time more precise information on the premiums paid by hospitals in Florida. The FHA does not have at this time information for premiums paid by hospitals in California.

The crisis facing Florida's hospitals is very real and cannot be understated. We enclosed herewith for the Committee's consideration a compilation prepared by the Florida Academy of Emergency Room Physicians which synthesizes information reported on a county-by-county basis relating to the impact of the crisis on emergency room physicians. Additionally, we enclose herewith a compilation of county-by-county impact of the litigation crisis on physicians statewide. Hospitals rely upon the availability of physicians in a wide range of specialties who are willing to serve on staff in order to meet the needs of our communities. The medical needs of our communities simply cannot be met without physicians.

Another question asked was whether any emergency rooms have closed during this medical liability crisis. Though we are not aware of complete emergency rooms closing, the crucial question is whether emergency care services are being limited. Since even hospitals without emergency rooms will try and stabilize a patient to the best of their ability, one of the many problems this crisis is causing is the reduction of these services.

Please review the accompanying reports detailing the many accounts of how emergency services are deteriorating throughout Florida.

Finally, we would like to remind the Committee that this medical liability problem is another outbreak in a struggle that has plagued Florida physicians and hospitals for almost thirty years beginning in 1975. Some observers have termed this the "third medical liability insurance crisis." It is our position that this is not the third crisis but rather, it is the same crisis that has existed since 1975.

1975 was the first year that the symptoms of availability and affordability presented themselves. Many changes were made to Florida's tort system, a Joint Underwriting Association (JUA) and Patients Compensation Fund (PCF) were created, and physician/hospital-owned insurance organizations were formed. These changes made the symptoms temporarily recede. However, one of these tort reforms was held unconstitutional and the PCF structure was a failure.

When the symptoms reappeared in 1983, they lasted five years. They were addressed by a combination of legislative changes to Florida's tort system and by the providers themselves. Providers were able to absorb the increased cost or pass it on. Once again, the symptoms receded. However, some of these tort reforms were held unconstitutional or were changed in the courts.

Though Florida has gone through this problem twice before, this time it is much more serious. The Florida healthcare system is in a much different environment than the one that existed in the 1970s and 1980s. After 20 years of governmental public policy to limit healthcare costs by restricting and capping revenues, providers have little ability to absorb or pass on these large insurance premium increases. That public policy change forced 63 hospitals to close in Florida. Many of the remaining hospitals are not strong financially and must self-insure at the risk of under-funding their exposure.

This problem is extremely complex because it involves the healthcare system, the judicial system, and the insurance industry – three institutions that our Government regulates separately and pursuant to different public policy goals. Our Government regulates healthcare on many different fronts taking into consideration patient access, quality of care, and costs. Our Government must apply those same considerations to medical liability.

We thank you for your consideration.

Sincerely,

William A. Bell
General Counsel

THE STATUS OF EMERGENCY AND TRAUMA CARE IN FLORIDA

August 5, 2003

Introduction

Emergency and trauma care in Florida have been significantly compromised by the current professional liability crisis and unfavorable litigation climate in Florida. Emergency physicians throughout the state face increasing problems with our emergency and trauma systems. The true impact of the degradation of Florida's emergency/trauma care system falls on patients who need quick access to quality emergency medical care.

This document reflects a compilation and summary of affidavits make under oath. All of the following examples and comments have been directly obtained from the attached sworn affidavits provided by emergency physicians around the state. Examples are provided in this document on a county-by-county basis. Copies of the underlying affidavits will be provided to the Florida Senate, the Florida House of Representatives and to the Office of the Governor. Copies may otherwise be made available upon request.

County-by-County Impact

Bay

Specialty coverage for emergency and/or trauma care has compromised the provision of emergency/trauma care in the following specialty areas: emergency medicine, hand surgery, oral/maxillo facial surgery, orthopedics, otolaryngology, plastic surgery.

Local emergency physician group lost insurance and is now practicing "bare." The first insurer stopped writing coverage due to the insurer's financial failure and bankruptcy. The subsequent insurer refused renewal of the group's policy, stating that the climate in Florida was too adverse.

There are three plastic surgeons practicing in the community. One has resigned privileges at the reporting hospital.

There are three oral/maxillo facial surgeons practicing in the community. All three refuse to practice at the reporting hospital.

Several years ago, the entire group of eight orthopedists resigned privileges at the hospital. The hospital has temporarily addressed the problem.

Problem with physicians taking emergency call is a "business decision" for physicians, as the hospital is a public hospital having sovereign immunity protection. Accordingly,

when litigation results, the emergency care physicians become the exclusive and collective "deep pocket."

Brevard

Specialty coverage for emergency and/or trauma care has compromised the provision of emergency/trauma care in the following specialty areas: cardiology, emergency medicine, general surgery, hand surgery, neurology, oral/maxillo facial surgery, orthopedics, pediatrics/pediatric surgery, radiology, urology, vascular surgery. The area is having difficulty recruiting emergency medicine physicians.

Neurology back up is not available at this reporting hospital emergency department. Patients must be transferred to other hospitals.

The local hospital has been unable to start a pediatric intensive care unit because of pediatricians' liability concerns.

Surgeons are not doing surgery with pediatric patients. General surgeons are not taking trauma call.

This reporting emergency physician indicates that patients often cannot get specialty care when the patients need such care.

Nearly all specialists have dropped privileges at Palm Bay Community Hospital.

There is no neurologist available to care for patients having strokes.

Orthopedic surgeons are available only 50% of the time.

Many surgical specialists, such as cardio thoracic surgeons and urologists, have stopped treating patients under 18 years of age.

Hand surgery is not available 75% of the time. On at least two occasions, the reporting physician has been unable to get any hand surgeon to care for hand emergencies. This was despite calling every hand surgeon in Brevard County and hand surgeons at major referral centers in Miami, West Palm Beach, Orlando, Tampa, Daytona Beach, Gainesville, and Jacksonville.

Broward

Specialty coverage for emergency and/or trauma care has compromised the provision of emergency/trauma care in the following specialty areas: emergency medicine, hand surgery, neurology, neurosurgery.

Neurosurgery: All neurosurgeons resigned from the hospital staff of the reporting hospital emergency department. Currently, the hospital has no neurosurgical capabilities.

Patients in need of neurosurgical services are transferred. This creates delays in care that can be detrimental to patient outcomes.

Neurology: The reporting hospital emergency department has lost most of its neurologists and is unable to secure the services of the remaining neurologists on a rapid emergency basis. Currently, treatment for a patient suffering with an acute ischemic stroke is administration of thrombolytic medication within the initial 3 hours of symptom onset. Per established guidelines, a stroke team, which includes a neurologist, should make the determination as to administration of this medication. With the inability to obtain rapid neurological consultation, the hospital emergency department has been hobbled in its ability to administer this treatment.

Hand Surgery: Over the past two years, the reporting hospital emergency department has lost many of its hand surgeons and some of those remaining have voiced their intention to drop their hand privileges. It is not unusual to have patients wait for many hours until a hand surgeon is available to care for the patients' injuries. This delay increases the chance for a bad outcome.

Emergency Medicine: The lack of specialist physicians causes the emergency department physician to expend time finding a specialist to care for the patient and/or arranging for the transfer of the patient. While the physician is spending time with these tasks, he/she is delayed in attending other patients waiting to be cared for in the emergency department.

Charlotte

Specialty coverage for emergency and/or trauma care has compromised the provision of emergency/trauma care in the following specialty areas: burns, cardiac surgery, dermatology, emergency medicine, gastroenterology, general surgery, gynecology, hand surgery, internal medicine, neurosurgery, obstetrics, ophthalmology, oral/maxillo facial surgery, pediatrics/pediatric surgery, plastic surgery, psychiatry, radiology.

Local specialists are reluctant to take ER call or care for high-risk trauma patients.

The local emergency medicine group is unable to recruit emergency physicians.

There is no gasteroenterology on call at this reporting hospital emergency department.

General surgeons have left the state, leaving behind surgeons who are reluctant to assume the increased workload and risk of emergency patients.

This reporting hospital emergency department has lost hand surgery coverage one week/month.

One of the local EDs has completely lost neurosurgical coverage, causing increased load to other hospital emergency departments and delaying patient care.

Physicians are completely dropping OB portion of their practice due to high risks and high malpractice insurance costs.

Opthalmologists are considering dropping hospital privileges in order to avoid ER call.

Trauma care is strained both at the local community hospitals and at the trauma centers to which the hospital emergency departments refer trauma patients.

Plastic surgeons are reducing the level of their services.

The reporting hospital emergency department is facing alternate weeks of no hand surgery, neurosurgery and general surgery. Some patients must be transferred over 50 miles away to get needed services.

Collier

Specialty coverage for emergency and/or trauma care has compromised the provision of emergency/trauma care in the following specialty areas: general surgery, hand surgery

This reporting emergency physician indicates that three general surgeons have left.

This reporting emergency physician indicates that most serious hand cases must be transferred to Miami.

This reporting emergency physician indicates that the trauma center at Lee Memorial Hospital is threatening to close.

There are multiple problems finding general or hand surgical coverage.

None of the specialties (general surgery, hand surgery, or intensivists) choose to cover for any trauma patients in the affected hospital emergency department.

Duval

Specialty coverage for emergency and/or trauma care has compromised the provision of emergency/trauma care in the following specialty areas: burns, cardiology, cardiac surgery, emergency medicine, gastroenterology, general surgery, geriatrics, gynecology, hand surgery, internal medicine, neurology, neurosurgery, obstetrics, ophthalmology, oral/maxillo facial surgery, orthopedics, otolaryngology, pediatrics/pediatric surgery, plastic surgery, psychiatry, pulmonary medicine, radiology, thoracic surgery, trauma center care, urology, vascular surgery.

In the past few months, one reporting hospital emergency department has had to transfer 10 critical patients by helicopter from Jacksonville to Gainesville for pediatric neurosurgical care, because there is no pediatric neurosurgical coverage in that tertiary

care center. This has resulted in serious medical risk to these patients and added great expense.

A second reporting hospital emergency department indicates that there is no pediatric neurosurgery available to emergency departments in Jacksonville.

Another reporting emergency physician indicates that emergent transfers of pediatric neurosurgical patients from Jacksonville to Gainesville occur repeatedly.

Another reporting emergency physician indicates that it is very difficult to get neurosurgeons, especially if the patient is less than 18 years old. All pediatric patients with neurosurgical needs have to be transferred by Life Flight to Gainesville.

Another reporting emergency physician indicates that there is no pediatric neurosurgical coverage in Duval County or in surrounding counties. This physician further indicates that no hand surgery coverage is available at many hospitals.

There was no hand surgery or cardiovascular call for six weeks this year at one reporting emergency department.

One reporting hospital emergency department indicates that many people cannot have heart catheterization due to lack of cardio thoracic back up. This puts these patients at unnecessary risk.

Surgeons have taken a leave of absence due to the malpractice crisis.

This reporting emergency physician indicates that access to general surgeons was extremely limited to patients in our region. Emergency departments were made to transfer patients to different facilities to receive proper care.

The current crisis has limited the availability of the general surgeon, which in turn, has a chain reaction on nearly all other specialties, since the general surgeon is everyone's back up.

ER patients have had limited access to all surgical specialties as a direct result of the cost/availability of liability insurance. It is particularly difficult getting orthopedic, hand and general surgical ER consults.

The current malpractice crisis has made specialties unavailable to many patients, forcing emergency physicians to transfer patients, sometimes hundreds of miles away, in order to receive the care they need.

Lack of specialty care creates additional risks to patients related to delays in care, while emergency physicians attempt to find appropriate care, often involving transfer to other facilities. The transferring of patients compromises the ability of emergency physicians to provide care to other patients in the emergency department and places other emergency

patients in jeopardy due to the situation. The transferring of patients prolongs care and slows the emergency care system greatly.

This reporting emergency physician expresses concern regarding long delays in obtaining appropriate treatment and critical care for patients and with the need to transfer patients to other hospitals with appropriate services.

This reporting emergency physician expresses concern that multiple patients require transfer, putting the patients at risk, delaying definitive care and treatment, and causing significant added time spent on non-medical issues (i.e. administrative). This is unsafe and dangerous.

This reporting emergency physician indicates that patients in the reporting hospital emergency department have been subject to loss of specialty care (i.e. no hand surgery, cardiac, orthopedic, general surgery or plastic surgery available). These specialists have either moved to other states or taken early retirement, because they cannot afford malpractice insurance.

This reporting emergency physician indicates that internal medicine specialists at the affected hospital are trying to stop admitting patients.

This reporting emergency physician states: "Sadly, each day I spend time begging other hospitals, some out of town, to give needed care."

Another reporting emergency physician states: "We, in the emergency department, frequently lack call coverage in many specialties, requiring extended stays in the emergency department without the evaluation of specialists, extended attempts to move patients to hospitals with specialized care, and sometimes patients not receiving the care they need for their emergency conditions."

This reporting emergency physician states that general surgery coverage in our region has been specifically devastated by the medical malpractice crisis. Hand surgery coverage is almost non-existent. Emergency room overcrowding has dramatically increased due to the lack of access to primary and specialty care.

Critical neurosurgical patients have been transferred to other hospitals.

At one reporting hospital emergency department, general surgery call is not available 94% of the time, requiring transfer of patients to distant facilities.

Emergency department volume has increased due to the unavailability of appointments in specialists' offices.

One reporting hospital emergency department indicates that young pregnant women are presenting at hospital emergency departments for deliveries due to the decreased number of OB/GYNs.

One reporting hospital emergency department indicates that there are hand injuries that need to be transferred to hospitals several counties away. If reattachment was possible, this delay in care may prevent attempts at doing so due to the time involved in the transfer.

One reporting emergency physician notes that lack of specialists results in long waits, bad outcomes and angry families.

Subspecialists are retiring or reducing ER availability.

This reporting emergency physician indicates that the following specialties have not been available when needed: general surgery, hand surgery, orthopedics, pediatrics/pediatric surgery, plastic surgery.

Franklin

Specialty coverage for emergency and/or trauma care has compromised the provision of emergency/trauma care in the following specialty areas: general surgery, hand surgery, internal medicine, neurology, orthopedics, plastic surgery.

Weems Memorial Hospital in Apalachicola is one of the most rural hospitals in the state (farthest from any medical center). Due to the high risk of practicing emergency medicine in this rural setting, the medical director of the emergency department was unable to secure traditional insurance, in spite of no claims history. His insurance, through the JUA, works out to a cost of approximately $50 per patient visit. His average reimbursement for each Medicaid patient is about $28. Many patients (35-40%) at the facility pay nothing at all.

The medical director was initially working up to 600 hours/month, as he was planning to take on a couple of partners, also board certified in Emergency Medicine. In spite of national advertising, there were no inquiries from out of state.

Specialty/follow-up care is especially difficult for a rural hospital.

In this region of fishermen and oystermen, hand surgery is a major issue and good care is vital to these workers. Finding physicians to accept such patients is difficult.

Hillsborough

Specialty coverage for emergency and/or trauma care has compromised the provision of emergency/trauma care in the following specialty areas: burn, general surgery, hand surgery, neurology, neurosurgery, obstetrics, ophthalmology, oral/maxillo facial surgery, orthopedics, otolaryngology; pediatrics/pediatric surgery, plastic surgery, psychiatry, trauma center care.

Physicians do not want to take liability for emergency patients, whether insured or not.

Trauma centers are not taking patients readily because they are overwhelmed.

This reporting emergency physician indicates that, in most cases, transfers of patients to tertiary hospitals have become difficult because specialists decline to accept the cases.

This reporting emergency physician working at a Hillsborough County trauma center is overwhelmed with pediatric neurosurgical cases from hospitals no longer willing to care for those patients, This physician indicates that no neurosurgeons will accept pediatrics.

This reporting emergency physician at a Hillsborough County trauma center indicates that pediatric/pediatric surgery is unavailable. Routine pediatric surgical cases must be transferred.

This reporting emergency physician at a Hillsborough County trauma center is overwhelmed with referrals from other hospitals that no longer have subspecialty coverage.

This reporting emergency physician at a Hillsborough County teaching hospital states that new graduate residents are not staying in Florida because they cannot afford malpractice insurance.

Indian River

Specialty coverage for emergency and/or trauma care has compromised the provision of emergency/trauma care in the following specialty areas: burns, emergency medicine, gynecology, hand surgery, neurosurgery, obstetrics, ophthalmology, oral/maxillo facial surgery, otolaryngology, pediatrics/pediatric surgery, thoracic surgery, trauma center care.

This reporting hospital emergency department indicates that there is no obstetric care in the hospital. Women in active labor must be delivered in the ER by an ER physician, without fetal monitoring or the ability to do emergency C-sections.

In a small emergency department, patient care is frequently made more difficult by lack of specialists in OB-GYN, neurosurgery, vascular surgery, trauma and pediatrics. If a patient requires immediate care by a specialist, valuable time is lost trying to find an available specialist at another hospital. This has become a more difficult problem over the last two years.

Lake

Specialty coverage for emergency and/or trauma care has compromised the provision of emergency/trauma care in the following specialty areas: emergency medicine, hand surgery, obstetrics

This reporting emergency physician is the managing partner for an emergency physician group that cares for more than 200,000 patients per year in 7 EDs throughout Central Florida (Orange, Seminole, Osceola, Lake, and Marion counties). The hospitals include: Orlando Regional Medical Center (Level I Trauma Center), Sand Lake Hospital, South Seminole Hospital, St. Cloud Hospital, South Lake Hospital, The Villages Regional Hospital. This reporting emergency physician states that access to care is being threatened in our emergency departments, our healthcare safety net, for multiple reasons. Medical malpractice reform is crucial to remove one of the disincentives that currently exist for physicians to provide care to emergency patients. The reporting emergency physician indicates that patients' access to specialists has been affected in all of our EDs in the Orlando Regional Healthcare System.

This reporting emergency physician indicates that governmental and private payors have been reducing reimbursement while are patients are ever more ill and emergency department services are ever more complex. The affected emergency physician group has seen medical liability insurance options dwindle, and have experienced 100% and 140% increases in liability insurance costs in the past two years. To face personal financial ruin with the specter of a multimillion-dollar claim for services provided under governmental mandate (i.e. EMTALA) and often without compensation does not seem to be a sustainable proposition unless action is taken. Important to the stability of emergency services is the recognition of the special role that EDs play in the care of the must acutely ill and underserved.

This reporting emergency physician indicates that neurosurgery coverage at Leesburg Regional Medical Center, the largest hospital is Lake County, is hampered by the fact that there is only one neurosurgeon on staff, and he is not available to take call all of the time.

Lee

Specialty coverage for emergency and/or trauma care has compromised the provision of emergency/trauma care in the following specialty areas: burns, cardiology, cardiac surgery, emergency medicine, gastroenterology, gynecology, obstetrics, pediatrics/pediatric surgery, psychiatry, trauma center, thoracic surgery, vascular surgery.

Hospitals in the county must transfer burns to Tampa.

Local ability to get a vascular or cardiovascular surgeon to treat a dissecting or ruptured thoracolumar aneurysm has disappeared due to high liability over the past 18 months. This local hospital now refers these extremely critical patients out of state for repair.

Recruiting emergency physicians in Florida has been much more difficult over the past 12 months. One local emergency group was unable to fill a vacancy for 12 months. Finally, a recently graduated physician filled the vacancy.

There has been great difficulty with hiring emergency physicians due to malpractice environment.

There is no gynecology, obstetrics, pediatrics/pediatric surgery or psychiatry available to this reporting hospital emergency department. There is limited availability of gastroenterology, internal medicine, vascular surgery, and dermatology.

Physicians working for hospitals with sovereign immunity versus those without sovereign immunity has created a serious disadvantage in the ability of the non-sovereign immunity groups to recruit and maintain emergency medical staff. Many specialists have left the reporting non-sovereign immunity hospital staff to join staff at the local sovereign immunity hospital – to avoid excessive exposure to liability.

The increase in malpractice premiums has left fewer dollars for salaries. As Florida is competing for emergency physicians on a national level, Florida groups can either offer fewer hours or less money. Either way, the final outcome is more limited access to patients – either fewer doctors (not coming to Florida) or fewer patient care hours. Practically, this results in longer waits for patients and increased workloads for physicians.

Manatee

Specialty coverage for emergency and/or trauma care has compromised the provision of emergency/trauma care in the following specialty areas: burns, cardiology, cardiac surgery, emergency medicine, general surgery, gynecology, hand surgery, neurosurgery, obstetrics, oral/maxillo facial surgery, orthopedics, otolaryngology, pediatrics/pediatric surgery, plastic surgery, psychiatry, radiology, thoracic surgery, vascular surgery.

The liability crisis has limited severely the coverage of specialists in our hospital emergency department.

Recruiting of emergency physicians has been very difficult due to the cost of insurance.

One reporting hospital emergency department indicates that more than half of the general surgeons have resigned from staff, primarily to avoid ER call.

Marion

Specialty coverage for emergency and/or trauma care has compromised the provision of emergency/trauma care in the following specialty areas: emergency medicine, general surgery, hand surgery, neurology, ophthalmology.

This reporting hospital emergency department has no GYN, ophthalmology, or neurosurgery.

On call neurology is limited. Two neurologists take consults only.

Martin

Specialty coverage for emergency and/or trauma care has compromised the provision of emergency/trauma care in the following specialty areas: cardiovascular surgery, gastroenterology, general surgery, gynecology, neurology, neurosurgery, orthopedics, pediatrics/pediatric surgery, plastic surgery, thoracic surgery, vascular surgery

This reporting emergency physician indicates that physicians do not want to perform any procedures or surgery that is risky, but needed. The physicians are competent and trained to perform such measures, but patients are sent to distant facilities, thereby delaying care and increasing expense.

Miami-Dade

Specialty coverage for emergency and/or trauma care has compromised the provision of emergency/trauma care in the following specialty areas: cardiology, cardiac surgery, emergency medicine, general surgery, hand surgery, neurosurgery, obstetrics, oral/maxillo facial surgery, orthopedics, otolaryngology, psychiatric, radiology, thoracic surgery, vascular surgery.

This reporting emergency physician indicates that the hospital where he practices has eliminated the on call neurosurgery coverage in the emergency department. Patients are transferred to another hospital.

This reporting emergency physician indicates that, at the affected hospital, otolaryngologists have not taken ER call for the past few years because they do not want to take the liability of ER patients.

This reporting emergency physician indicates that three orthopedic surgeons have dropped privileges at the affected hospital because they cannot add the liability of ER calls. There is only one orthopedic physician that covers only one week of the month. During the remaining three weeks of each month, patients must be transferred to other facilities.

This reporting emergency physician indicates that many facilities have faced decreased staffing of emergency physicians due to the escalating cost of malpractice premiums

This reporting emergency physician indicates that several Dade County hospitals are having difficulty with availability of hand surgeons for emergency call. The emergency physician understands that existing practices or facilities have had difficulty recruiting hand surgeons.

This reporting emergency physician indicates that Mount Sinai Hospital has been required to contract with one physician to provide obstetric care. All other obstetricians refuse. Many physicians have left OB practice.

This reporting emergency physician indicates that there are problems obtaining radiology services at several Dade County hospitals. Many radiologists have retired, left the state, or moved practices to diagnostic centers.

This reporting emergency physician indicates that thoracic surgeons refuse high-risk patients, directing the emergency department to transfer patients to other facilities.

This reporting emergency physician indicates that emergency physician staffing cannot increase despite any increased patient volume.

This reporting emergency physician indicates that staff specialty physicians drop off emergency call or completely drop staff privileges. Such physicians indicate: "all my risk is through the ER."

The reporting emergency physician indicates that staff physicians in key specialties are moving or are retiring early. New physicians cannot be recruited into practices.

Orange

Specialty coverage for emergency and/or trauma care has compromised the provision of emergency/trauma care in the following specialty areas: burns, cardiology, emergency medicine, gastroenterology, general surgery, gynecology, hand surgery, neurology, neurosurgery, obstetrics, ophthalmology, oral/maxillo facial surgery, orthopedics, otolaryngology, pediatrics/pediatric surgery, plastic surgery, psychiatry, radiology, thoracic surgery, trauma center care, urology, vascular surgery

High levels of malpractice cases and costs have made it more difficult to provide care to Level I trauma patients.

Decreased availability of neurosurgeons almost caused the Level I trauma center to close and actually still threatens the trauma center closing.

Practice of this reporting physician is in a system comprised of seven hospitals in Orange, Osceola and Seminole counties. The region's EDs have been crippled by the lack of on call specialty care and closings of complete departments within individual hospitals making vital services, like general surgery, obstetrics and gynecology, orthopedic surgery and neurosurgery unavailable, mandating the transfer of the affected patients to other facilities, at the peril of the patient, while delaying timely care.

Only 1 neurosurgeon is on call daily for 7 hospitals in a hospital system.

At this reporting hospital emergency department, there is no general surgery coverage. All cases involving the following specialties must be transferred to a different facility: orthopedics, obstetrics, general surgery, hand surgery, neurosurgery, otolaryngology, urology.

Patients with critical needs for specialty care cannot be taken care of properly due to lack of specialists.

One reporting hospital emergency department indicates that coverage for hand and neurosurgery is difficult and that access to care has been limited. This problem is ongoing. It is apparently difficult to recruit new physicians and keep older ones. This problem is escalating.

One reporting hospital emergency department indicates that surgical availability is limited. The emergency department frequently must transfer patients. There is no available cardiovascular, gastroenterology, neurosurgery or psychiatry. There is limited general surgery, hand surgery and pediatrics. The professional liability and litigation climate has had a significant impact on the availability of specialists. Specialists have become unavailable to the ED recently, where in the past the specialty coverage was excellent. This has resulted in delays, transfers, and crowding of the ED awaiting specialists, as well as potential risks to patients due to delays and transfers.

There is no orthopedic or general surgery on many campuses.

Long distance transfers are required for neurosurgery patients.

There is a lack of microvascular/hand surgery care.

OB/GYN is unavailable to care for intraabdominal ectopic pregnancy at this reporting emergency department.

Reporting trauma center emergency physician reports problems in recruiting and shortages in various physician specialties.

Reporting hospital emergency physician reports a lack of hand surgeons, urologists and neurosurgeons.

Physicians are increasingly reluctant to take call due to liability issues.

Osceola

Specialty coverage for emergency and/or trauma care has compromised the provision of emergency/trauma care in the following specialty areas: cardiology, emergency medicine, general surgery, gynecology, hand surgery, internal medicine, neurosurgery, obstetrics, orthopedics, ophthalmology, pediatrics/pediatric surgery, plastic surgery, psychiatry, radiology, urology.

This reporting hospital emergency department recently lost two days of general surgery coverage per week.

This reporting hospital emergency department indicates that psychiatric patients may wait for days to see a psychiatrist.

Several hospitals share emergency call for specialty services. This results in one hospital ED needing a specialist "stat", while that specialist is occupied at another hospital, thus delaying needed emergency care.

A common denominator is lack of enough specialists to provide adequate coverage to the ED. This leads to frequent transfers of patients to other hospitals to obtain care.

Emergency physicians are becoming reluctant to work in hospitals with little specialty back-up availability.

Practice of this reporting physician is in a system comprised of seven hospitals in Orange, Osceola and Seminole counties. The region's EDs have been crippled by the lack of on call specialty care and closings of complete departments within individual hospitals making vital services, like general surgery, obstetrics and gynecology, orthopedic surgery and neurosurgery unavailable, mandating the transfer of the affected patients to other facilities, at the peril of the patient, while delaying timely care.

Palm Beach

Specialty coverage for emergency and/or trauma care has compromised the provision of emergency/trauma care in the following specialty areas: burns, emergency medicine, general surgery, gynecology, hand surgery, neurology, neurosurgery, obstetrics, ophthalmology, orthopedics, pediatrics/pediatric surgery, thoracic surgery, trauma care, oral/maxillo facial surgery, otolaryngology

All of the neurologists in northern Palm Beach County have withdrawn from service call coverage. Emergency physicians field calls daily from other emergency departments looking to transfer patients with neurological emergencies.

Neurologists in the reporting hospital emergency department no longer perform lumbar punctures because of the liability. This has placed an additional burden and liability on the emergency physicians and interventional radiologists.

This reporting emergency physician indicates the neurologists are not available to take call and evaluate an acute stroke for possible thrombolysis in Palm Beach County.

There is no neurosurgical coverage for most of the month in this reporting hospital emergency department. The neurosurgeon has dropped privileges to do any aneurysms. No neurosurgeon will operate on aneurysms (nontraumatic) in Palm Beach County as well as parts of Broward and Martin Counties.

Reporting emergency physician recently cared for and tried to transfer one particular neurosurgical patient, while the emergency department filled up with other sick patients

waiting to be seen. None of the 22 hospitals with neurosurgeons that were contacted would take aneurysms because of their "high liability" and inevitable poor outcomes. The patient died.

This reporting hospital emergency department has no opthalmologist on staff, no hand surgery and no ENT.

At this reporting hospital emergency department, all of the surgeons have dropped ER coverage and most of the surgeons send their sickest patients to the ED because doing so limits the physicians' risk.

In the past two years, the reporting emergency department hospital staff has lost three neurosurgeons and gained none. The hospital no longer has a neurosurgical call roster and cannot offer these services to patients presenting with a neurosurgical emergency. This has resulted in delays in getting transfers accepted and further delays in transport. Delays are generally deleterious to a patient with an acute neurosurgical emergency. Patients are suffering poor outcomes because of this delay.

This reporting hospital emergency department is the only hospital in a multi-county region with ophthalmology service call coverage. This results in patients having to be transferred up to 80 miles for this service. Ophalmologists at this hospital are being overwhelmed by this situation and they will likely stop taking service call by the end of the year.

The emergency medicine group that services this reporting hospital emergency department has not been able to expand coverage optimally to meet the burgeoning patient volume. This is largely due to rising malpractice costs. The emergency physicians have instead implemented a lesser increase in physician coverage and taken a significant pay cut to try and provide adequate physician coverage for the patient volume. If premiums increase again next year, the emergency physician group will be forced to decrease physician coverage. Decreased physician coverage is directly correlated with longer wait times and correlated with decreased patient satisfaction. There is also a higher probability of diminished patient care with fewer physicians taking care of larger numbers of patients. The patient population served by these physicians is largely elderly with high acuity medical problems.

This reporting hospital emergency department indicates that pediatricians refuse to see patients under 12 years old and general surgeons will no longer perform routine pediatric cases.

This reporting hospital emergency department reports a lack of trauma coverage.

This reporting emergency physician indicates that neurosurgeons and neurologists have completely pulled off of ER call. Additionally, most neurologists no longer do spinal taps.

This reporting emergency physician indicates that the affected ER group used to receive numerous resumes from well-trained doctors each month. Now the group must actively recruit to obtain needed physicians. Despite the paradise that south Florida offers and the increased opportunities, physicians are not coming. The population in south Florida continues to explode, but new doctors will not come. The doctor to patient ratio is dwindling.

This reporting hospital emergency department had eight neurologists on the hospital staff three years ago. Now, there are only two neurologists on staff and these neurologists will not take emergency call. This dramatically affects care for stroke patients.

This reporting hospital emergency department used to have three neurosurgeons on hospital staff. Now there are none.

This reporting emergency physician indicates that there are no neurosurgeons in south Palm Beach County who treat aneurysms. Transporting these patients to distant, overwhelmed facilities causes life-threatening delays. The last patient that this emergency physician transported, who died, was in his thirties.

This reporting emergency physician indicates that Bethesda Medical Center no longer has hand specialists on staff. Hand injuries are common and cripple hard-working people.

This reporting hospital emergency department indicates that at least two of the hospital's obstetricians have stopped delivering babies.

This reporting emergency physician knows of two internists from the affected facility at West Boca who are leaving the state and one who is retiring early.

This reporting emergency physician indicates that at least one orthopedic group at West Boca no longer treat spine injuries. Back pain is one of the most common complaints in the ER.

This reporting emergency physician indicates that Boca Community Hospital no longer has oral surgeons available.

This reporting emergency physician indicates that one of the on-call ophthalmologists is leaving hospital staff.

This reporting hospital emergency department indicates that the emergency department has no neurosurgery and no neurology coverage. The closest hospitals will not take transfers, as these hospitals similarly have no coverage.

Pinellas

Specialty coverage for emergency and/or trauma care has compromised the provision of emergency/trauma care in the following specialty areas: general surgery, hand surgery,

neurosurgery, obstetrics, ophthalmology, oral/maxillo facial surgery, plastic surgery, psychiatry, urology

This reporting hospital emergency department has had no new surgeons in the past five years. During the same period, one surgeon has restricted practice, then left the state; one surgeon is currently trying to leave the area; one surgeon has restricted practice and will not see trauma; two surgeons have restricted practice and will not see pediatric cases.

This reporting hospital emergency department has neurosurgery available only one week out of three. In the past three years, one neurosurgeon has moved out of state and one has retired.

This reporting hospital emergency department has no hand surgeons. All patients are transferred.

The OB unit of the hospital of this reporting emergency department closed in 2002.

This reporting hospital emergency department has only two weeks per month of plastic surgery coverage.

This reporting hospital emergency department has no psychiatrist available for ER call.

This reporting hospital emergency department has no new urologists. In the past four years, two urologists have retired and one has moved.

This reporting Pinellas County emergency physician indicates that the one overwhelming difficulty in emergency medicine is the difficulty of obtaining specialist coverage. With the growth the number of emergency department visits over the past five years, the difficulties with insurance coverage, and the growing number of elderly patients with complex problems, this physician has witnessed a declining number of specialists willing to take ER call and a definite decline in new specialists willing to move into Pinellas County.

The reporting emergency physician indicates that one of the major complaints of the specialists has been the liability exposure incurred by caring for emergency department patients. This is seen as a double burden. Not only is the specialist unable to see his own scheduled patients, but also he is frequently needed to provide uncompensated emergency care that incurs a significant liability risk. Not only does he lose income, but he also has to purchase malpractice insurance to cover his care for the emergency patient. This lack of back-up specialist care is beginning to severely threaten the safety net of emergency health care. It has the effect of forcing emergency medicine physicians to practice at or beyond the limits of their competence just to provide temporary care, or force patients to be transferred and/or have their care excessively delayed. This unfortunately results in a general deterioration of emergency care at a time when the public needs it more than ever.

Pinellas case example: A husband of a patient fainted during a blood draw, fracturing his mandible in four places. It took more than seven hours to find an oral surgeon willing to take the patient, and then the patient had to be transferred to another facility. Not only was this patient's care delayed, the other patients in the ER had care delayed while personnel were occupied making multiple phone calls, waiting for return calls, and caring for a patient in the ED that should have gone to the operating room hours earlier.

Pinellas case example: An elderly female fell at home and fractured her neck. No neurosurgeon could be found in Pinellas County that was available or willing to accept the patient. It was necessary to send the patient to Orlando for neurosurgical care. This required hours of phone calls and contacts, and a long transfer to a distant city. Neurosurgical coverage is a serious problem in Pinellas County.

This reporting emergency physician indicates that in his region there have been multiple closures of OB units.

This reporting emergency physician indicates that there is very restricted coverage of neurosurgery, which varies day by day.

This reporting emergency physician indicates that hand, plastics and otolaryngology are almost nonexistent in the community hospitals of West Central Florida.

This reporting emergency physician indicates that presently there are multiple facilities facing resignations from staff of orthopedics and general surgeons. These specialties are necessary to being able to provide emergency care.

St. Johns

Specialty coverage for emergency and/or trauma care has compromised the provision of emergency/trauma care in the following specialty areas: general surgery, neurosurgery, oral/maxillo facial surgery, ophthalmology, pediatrics/pediatric surgery, plastic surgery, thoracic surgery, urology, vascular surgery.

This reporting emergency physician indicates that subspecialists are retiring or reducing ER availability.

Sarasota

This medical director for emergency medical services (EMS) in Sarasota has been unable to obtain malpractice insurance coverage for his EMS duties and has to give up this job in which he has served since 1974.

Seminole

Specialty coverage for emergency and/or trauma care has compromised the provision of emergency/trauma care in the following specialty areas: emergency medicine, hand

surgery, ophthalmology, otolaryngology, orthopedics, neurosurgery, trauma center care, urology

This hospital emergency department has no in-house orthopedic on call coverage 50% of the time, requiring transfer of patients.

This reporting emergency physician indicates that a lack of orthopedic call compromises trauma care.

This hospital emergency department has a shortage of neurosurgery coverage, resulting in transfers and delaying care in life-threatening neurosurgical emergencies.

Practice of this reporting physician is in a system comprised of seven hospitals in Orange, Osceola and Seminole counties. This region's EDs have been crippled by the lack of on call specialty care and closings of complete departments within individual hospitals making vital services, like general surgery, obstetrics and gynecology, orthopedic surgery and neurosurgery unavailable, mandating the transfer of the affected patients to other facilities, at the peril of the patient, while delaying timely care.

Volusia

Specialty coverage for emergency and/or trauma care has compromised the provision of emergency/trauma care in the following specialty areas: cardiovascular surgery, general surgery, gynecology, neurosurgery, obstetrics, opthalmology, otolaryngology, pediatrics/pediatric surgery, psychiatry, radiology, trauma center care

This reporting emergency physician indicates Florida Hospital Fish Memorial has recently experienced a major decrease in the number of privileged OB/GYN physicians to the point where the emergency room at Fish Memorial is no longer able to offer 24/7 coverage. There is no obstetrics department at this hospital whose service area includes both the largest city in Volusia County (Deltona), and the fastest growing city in Volusia County.

This reporting emergency physician indicates that there is no pediatric department at the affected Volusia County hospital. Sick pediatric patients must be transferred to one of the two tertiary care hospitals in Orlando. Bed available for these transfer patients at the accepting facilities is frequently scarce and, consequently, sick pediatric patients, who, otherwise, would require intensive pediatric care services, must be managed in the local emergency room.

This reporting emergency physician indicates that general surgery coverage reached a crisis several months ago, when a very active three person surgical practice had to quit practicing temporarily because they could not afford to pay for professional liability insurance. The group subsequently resumed practice, but has pulled out of practice at the affected hospital. The emergency physician understands that another two-person surgery practice based in Deland is also planning to cease practice at the hospital.

Neurosurgery coverage is non-existent at Fish Memorial.

Opthalmology and ENT coverage present a problem in that there are no such physicians on staff at the neighboring hospital in Deland. Consequently, whenever a patient with an eye, ear, nose or throat problem presents to the affected hospital, the patient must be transferred.

This reporting emergency physician indicates that there is no psychiatry coverage for the ER at Fish Memorial.

This reporting emergency physician states that trauma services in Volusia County are "hanging by a thread" as the trauma surgeons at Halifax Medical Center have publicly stated their intention to stop seeing trauma patients if they do not obtain relief from the medical malpractice crisis soon.

* This report was last updated on August 11, 2003

County Specific Impact Report

The following report documents how the medical liability crisis is eroding healthcare services around the state. These facts were drawn from press accounts and from information reported directly by hospitals or physician practices. This report is not intended to be all-inclusive, as physician practices are changing on an almost daily basis.

SOUTH FLORIDA

Broward County

- University Hospital & Medical Center eliminated on-call obstetrical and gynecology coverage in its emergency department. (University Hospital & Medical Center, January 2003, FHA Survey)
- A thoracic surgeon and three partners closed their office and were only treating current patients on an emergency basis. (*Palm Beach Post*, May 20, 2003)
- At least five neurosurgeons stopped taking new patients and conducting elective surgery and, in some cases, cut back on emergency room participation. (*Miami Herald*, May 28, 2003)
- An on-call neurosurgeon at Broward General's emergency room – who provided 40 percent of the on-call coverage per month – decided to move to Long Island. (*Miami Herald*, May 28, 2003)
- Northwest Medical Center opted to discontinue Oral-Maxillary services. All patients who arrive at the ER must be transferred to another facility. (Northwest Medical Center, July 2003, FHA Survey)
- Dr. Lubomir Yazov of Fort Lauderdale said he is facing double and triple increases in his medical liability insurance premium for one-fourth the coverage. Dr. Yazov said this precludes him from practicing normal medicine and forces him to close his office. (Dr. Lubomir Yazov, January 2003 academic task force report)
- Dr. Gerald Alan Spunt, a pediatrician in Broward County, has been in private practice for 25 years. His group is facing the prospects of paying four times the amount it paid two years ago for insurance. The worst-case scenario is that they will be denied coverage and forced to go bare. (Dr. Gerald Alan Spunt, January 2003 academic task force)
- Dr. Brad Chayet is a member of a seven-person multi-specialty orthopedic group in West Broward. His premiums have doubled; his intention is to go bare and to avoid very high-risk procedures. (Dr. Brad Chayet, January 2003 academic task force)
- Dr. Mararita Alarcon — Practice: Diagnostic Radiology. Group had to self-insure and cannot hire new radiologists. (Florida Medical Association affidavit)
- Dr. Roger Buzatu — Practice: General Surgery. Stopped performing complex/high-risk procedures. (Florida Medical Association affidavit)

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- Dr. Phillip Caruso — Practice: Gynecology. Stopped ER Call and high-risk surgery. (Florida Medical Association affidavit)
- Dr. Richard P. Edison — Practice: Surgery. Plans to retire much earlier than expected. (Florida Medical Association affidavit)
- Dr. Herman Epstein — Practice: OB/GYN. Limited OB practice. Stopped performing cancer surgeries and limited surgical procedures. (Florida Medical Association affidavit)
- Dr. Jay Fine — Practice: Plastic Surgery. Stopped surgery and trauma work; will limit practice to part-time. (Florida Medical Association affidavit)
- Dr. Bruce Fletcher — Practice: Orthopedic Surgery. Stopped performing high-risk surgery; gives away most of his ER calls. (Florida Medical Association affidavit)
- Dr. George Fournier — Practice: Ophthalmology. Does not perform high-risk surgery. (Florida Medical Association affidavit)
- Dr. Jose Garcia — Practice: Rheumatology. Spending less time with patients so that more can be seen to cover expenses. (Florida Medical Association affidavit)
- Dr. F. Gary Gieseke — Practice: Neurosurgery. Stopped treating pediatric and any high-risk cases. (Florida Medical Association affidavit)
- Dr. Mark Gordon — Practice: General Surgery. Stopped seeing high-risk patients. (Florida Medical Association affidavit)
- Dr. Gerald Halpern — Practice: Urology. Stopped performing many surgical procedures and is considering retirement. (Florida Medical Association affidavit)
- Dr. Melanie Hecker — Practice: Dermatology. Limited the amount of facial skin cancer removals. (Florida Medical Association affidavit)
- Dr. Robert Hirsch — Practice: Hematology/Oncology. Will stop seeing obstetrics patients. (Florida Medical Association affidavit)
- Dr. Stephen Jacobs — Practice: Orthopedic Surgery. Stopped ER coverage and high-risk surgical procedures. Refers patients to University of Miami. (Florida Medical Association affidavit)
- Dr. Bruce Janke — Practice: Orthopedic Surgery. Must be selective on cases taken. No longer carries malpractice insurance. (Florida Medical Association affidavit)
- Dr. Judith Johnson — Practice: General surgery/trauma. No longer takes general surgery ER calls, turns down high-risk cases, and cannot afford insurance. (Florida Medical Association affidavit)
- Dr. Alfred Kalman — Practice: Hematology/Oncology. Will not accept consults for any OB/GYN patients. (Florida Medical Association affidavit)

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- Dr. Marshall Kaplan — Practice: Urology. Stopped ER calls. (Florida Medical Association affidavit)
- Dr. Paul Kolbert — Practice: Anesthesia/Pain Management. Given up pain management. (Florida Medical Association affidavit)
- Dr. Alan Kramer — Practice: Rheumatology. Limiting the number of patients treated in the office, and restricting hospital practice to avoid risk. (Florida Medical Association affidavit)
- Dr. Meron Levitats — Practice: ENT. Total number of physicians in Broward county has dropped in past 5 years. (Florida Medical Association affidavit)
- Dr. Gaston Mendez — Practice: Diagnostic Radiology. Group had to self-insure. (Florida Medical Association affidavit)
- Dr. Indrek Miidla — Practice: General Surgery. Stopped malpractice insurance. (Florida Medical Association affidavit)
- Memorial Regional Hospital — Recruiting difficulty with "high malpractice" specialties. Losing physicians from practice - 3 left state, 4 retired early. Lack of on-call specialty coverage at local hospital emergency departments for orthopedics, surgery, neurosurgery and other key services resulting in patient transfers to Memorial Regional Hospital Emergency Department for care. Limited/reduced availability of screening of mammography services in the community, creating backlogs for services. (Florida Hospital Association affidavit)
- Dr. Matthew Moore — Practice: Neurology. No longer sees pediatric or high-risk patients. (Florida Medical Association affidavit)
- Dr. Navesh Pathak — Practice: Internal Medicine. Dropped ER call. (Florida Medical Association affidavit)
- Dr. Manuel Quintana — Practice: OB/GYN. Stopped high-risk OB deliveries, and may be forced to stop OB care. (Florida Medical Association affidavit)
- Dr. Michael Reilly — Practice: Orthopedic Surgery. Cannot afford the liability insurance. (Florida Medical Association affidavit)
- Dr. Donald Revis — Practice: Plastic Surgery. Stopped performing high-risk procedures, and stopped taking patients in the ER. (Florida Medical Association affidavit)
- Dr. Angela Rodrigues — Practice: Pediatrics. Might have to leave the state due to cost of insurance. (Florida Medical Association affidavit)
- Dr. Howard Ruskin — Practice: Neurology. Avoids seeing acutely ill patients. (Florida Medical Association affidavit)
- Dr. Brian Zeigler — Practice: Orthopedic Surgery. No longer performs high-risk procedures, especially with regard to trauma. (Florida Medical Association affidavit)

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- Dr. Erwin Vasquez — Practice: Internal Medicine. Avoids interventional cardiology. Avoids high-risk patients with poor outcome. Unable to get partners to expand or maintain practice. Planning premature retirement. (Florida Medical Association affidavit)
- Dr. Ana Tamayo — Practice: OB/GYN. I have decreased my total number of surgeries already. (Florida Medical Association affidavit)
- Dr. Paul Tocci — Practice: Urology. Stopped doing high-risk procedures. (Florida Medical Association affidavit)
- Dr. Russell Sassani — Practice: Plastic Surgery. Has limited extensive reconstructive procedures such as facial trauma and muscle flaps for breast cancer, especially on high-risk patients. Has seriously considered dropping malpractice coverage completely due to the high cost of premium. (Florida Medical Association affidavit)
- North Broward Medical Center — Knowledge of physicians who retired, left the state & stopped high-risk cases. (Florida Hospital Association affidavit)
- Dr. Jane Seyler — Practice: Pediatrics. Plans to leave FL to practice medicine in UK. Has had to stop carrying malpractice insurance because the premiums would have been equal to 2/3 of projected income. (Florida Medical Association affidavit)
- Dr. John Shaw — Practice: General Practice. Stopped coverage for doctors who do not have malpractice insurance. (Florida Medical Association affidavit)
- Dr. Alan Siegel — Practice: Pain Management. Patients considered to be high-risk or whose good outcomes cannot be routinely predicted are advised to seek care elsewhere. (Florida Medical Association affidavit)
- Dr. Mark Simon — Practice: Diagnostic Radiology. Has impeded efforts to hire additional radiologists. Even local medical school grads are seeking positions out of state. Group found it necessary to self-insure due to high liability insurance premium combined with low reimbursements. (Florida Medical Association affidavit)
- Dr. Helene Sinclair — Practice: Family Practice. Stopped providing hospital care for patients. (Florida Medical Association affidavit)
- Dr. Stanley Sinclair — Practice: Family Practice. Stopped providing hospital care for patients. Seriously considering early retirement within one year. Has no liability insurance. (Florida Medical Association affidavit)
- Dr. Irwin Steinberg — Practice: OB/GYN. Decreased the amount of gynecological services, performs very few vaginal births after ceasearean section. Does not perform any surgeries with high chances of post-operative complications. (Florida Medical Association affidavit)
- Dr. Amos Stoll — Practice: Neurosurgery. Has specifically stopped performing carotid surgeries. (Florida Medical Association affidavit)

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- Dr. Eugene Strasser — Practice: Plastic Surgery. Stopped treating hand trauma, chronic ulcers, free flaps, and burns. (Florida Medical Association affidavit)
- Dr. Harold Altschuler — Practice: Cardiology. Stopped cardiac caths, hospital rounds, temporary pacemakers, Swan Ganz cath insertion. (Florida Medical Association affidavit)
- Dr. Richard B. Antosek — Practice: Urology. Performs no radical cancer procedures, kidney stone & other difficult procedures. (Florida Medical Association affidavit)
- Dr. Jeffrey Barnes — Practice: Emergency Medicine. Sees multiple physicians not doing hospital work or specialties. Medical students leaving FL. (Florida Medical Association affidavit)
- Dr. Clifford Benezra — Practice: Pulmonary/Internal Med. Stopped high-risk patients & procedures
- Dr. Michael Benjamin — Practice: OB/GYN. Discontinued delivering babies. (Florida Medical Association affidavit)
- Dr. Kalman Blumberg — Practice: Spinal Surgery. No high-risk/complicated cases. Lost 2 physicians. Ins. quote $192,000 for 250/750. (Florida Medical Association affidavit)
- Dr. Jean-Claude Bourque — Practice: Family Practice. Might move, and has stopped performing minor surgeries, complex medical problems, and dysmetabolic synd. (Florida Medical Association affidavit)
- Memorial Hospital Pembroke — Difficulty recruiting general & orthopedic surgeons. Difficulty obtaining emergency department coverage by oral & orthopedic surgeons. Six physicians de-parted w/in last 12 months due to malpractice liability issue. (Florida Hospital Association affidavit)
- Dr. William Randy Burks — Practice: Ophthalmology. Stopped trauma care, seeing litigation cases, and refers any high-risk cases to University. (Florida Medical Association affidavit)
- Dr. Frank P. Catinella — Practice: Cardiovascular & Thoracic. Does not treat thoracic aneurysms or aortic dissections. (Florida Medical Association affidavit)
- Dr. O. Richard Cohen — Practice: Diagnostic Radiology. Impeded efforts to hire; group is now self-insured. (Florida Medical Association affidavit)
- Dr. Steven Cohn — Practice: Cardiology/Internal Medicine. Stopped ER call, stopped invasive cardiac procedures, and stopped caring for indigent. (Florida Medical Association affidavit)
- Dr. Ernest Constantine Jr. — Practice: Urology. Has retired due to malpractice insurance. (Florida Medical Association affidavit)

- Dr. Eugene N. Constantini — Practice: Cardiac, Vascular, Thoracic Surgery. Stopped high-risk cardiac cases, limb salvage, vascular surgery, among others. (Florida Medical Association affidavit)
- Dr. James DeLeo — Practice: Pediatrics. Increased patients I refer to be cared for by the hospitalists. (Florida Medical Association affidavit)
- University Hospital and Medical Center — Obstetrics ER coverage eliminated & daily problems w/securing ER coverage for other specialties. (Florida Hospital Association affidavit)
- Dr. David G. Droller — Practice: Infectious Diseases. Stopped seeing pregnant women. (Florida Medical Association affidavit)
- Dr. Jay Lieberman — Practice: Podiatric Medicine/Surg. Refers high-risk patients to others; malpractice has tripled in the last 2 years. (Florida Medical Association affidavit)
- Dr. Matthew Lief — Practice: Urology. Stopped ER call and high-risk surgery. (Florida Medical Association affidavit)
- Dr. Gary Magid — Practice: Psychiatry. No sucidial or homicidal patients; no one with any acute crisis involving psychosis. (Florida Medical Association affidavit)
- Dr. Fernando Mata — Practice: Psychiatry. Resigned from 3 hospitals; now outpatient only. (Florida Medical Association affidavit)
- Dr. Nathan Mayl — Practice: Plastic/Reconstructive. Stopped responding to emergency patients, and stopped performing hand surgeries. (Florida Medical Association affidavit)
- Dr. Wayne Mayson — Practice: Reproductive Endocrinology. Stopped performing hysterectomies and complicated GYN surgeries. (Florida Medical Association affidavit)
- Dr. Matthew Moore — Practice: Neurosurgery. No more pediatric or high-risk tumors despite training years to do it at Harvard Med. (Florida Medical Association affidavit)
- Dr. Harvan Nahmias — Practice: Endocrinology. Limited and reduced seeing pregnant patients with endocrine problems, and has reduced emergency patients. (Florida Medical Association affidavit)
- Dr. Abraham Rosenberg — Practice: Oncology. Stopped seeing all OB patients, and all patients coming in without insurance, and high-risk patients. (Florida Medical Association affidavit)
- Dr. Ram Madasu — Practice: Otolaryngology. Limited facial practice, and limited repair of facial fractures. (Florida Medical Association affidavit)

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- Dr. Alison Desouza — Practice: OB/GYN. No longer accepting high-risk obstetrics patients. (Florida Medical Association affidavit)
- Dr. Ira Fox — Practice: Anesthesia. Very selective on types of interventional treatments, and is referring some cases out of state. (Florida Medical Association affidavit)
- Memorial Hospital West — "High Malpractice" specialties difficult to recruit. Two physicians left state, 1 OB/GYN dropped OB, 3 left medical practice for admin. positions. (Florida Hospital Association affidavit)
- Dr. Maher Helmy — Practice: Orthopedic Surgery. No high-risk; stopped seeing children with certain traumas, developmental problems. (Florida Medical Association affidavit)
- Dr. Gaston Mendez — Practice: Intervention of Radiology. Complex cases referred out; high-risk procedures curtailed. (Florida Medical Association affidavit)
- Dr. David E. Perloff — Practice: Cardiology. Refuses Medicaid patients; no high-risk—reimbursement too low to justify risk. (Florida Medical Association affidavit)
- Dr. Neil Kato — Practice: Family Medicine. Resigned from staff of one hospital; refuses emergency call; don't admit hospital patients. (Florida Medical Association affidavit)
- Northwest Medical Center — Challenged w/mgmt of physician ER coverage. Oral/maxillary services discontinued. ER patients or inpatients needing consult will be transferred to another hospital for care & treatment. ENT subspecialty coverage has gone from 6 to 2 physicians. Minimum of 6 required. If last 2 leave will have to eliminate service. Now have to utilize those 2 physicians 24/7, 365 days a year. Physicians diminishing in subspecialties. In past 6 mo. 4 physicians left state, 4 OBs reduced practice & won't deliver babies. If complication w/pregnant patient, services limited due to high-risk service. (Florida Hospital Association affidavit)
- Dr. Arnold Ghirs — Practice: Interventional Cardiology. Has stopped certain invasive procedures. (Florida Medical Association affidavit)
- Dr. Arthur Gomberg — Practice: Family Practice. No longer accepts patients under 18 years of age, performs no more minor surgeries in office, and has reduced office hours. (Florida Medical Association affidavit)
- Dr. M.A. Hajianpour — Practice: Orthopedic Surgery. Revision of high-risk patients in need of intensive surgery or risks are very high. (Florida Medical Association affidavit)
- Dr. Jose Birriel Jr. — Practice: Pulmonary. Will not accept any more complex pulmonary patients. (Florida Medical Association affidavit)
- Dr. Jorge A. Perez — Practice: Plastic & Reconstructive Surgery. No more secondary reconstructive cases, children, or medically complicated cases. (Florida Medical Association affidavit)

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- Dr. Carlos Bejar — Practice: Nephrology. Partner left; no minor surgical procedures; no OB patients; no gastric bypass patients. (Florida Medical Association affidavit)
- Dr. George Rodriguez-Paz — Practice: Cardiology. Stopped doing TEE, ER patients, high-risk angioplasty patients; stopped seeing pregnant patients. (Florida Medical Association affidavit)
- Dr. Allan M. Rosenbaum — Practice: Otolaryngology-Head/Neck. Is eliminating high-risk procedures. One partner left the practice. (Florida Medical Association affidavit)
- Dr. Babak Sheikh — Practice: Orthopedic Surgery. No longer sees high-risk patients. (Florida Medical Association affidavit)
- Dr. Stanley Skipit — Practice: Dermatology. Stopped doing hair transplantations due to high medical liability insurance premiums. (Florida Medical Association affidavit)
- Dr. LeRoy A. Smith — Practice: Orthopedic Surgery. Has taken leave of absence—is unable to practice in this environment. (Florida Medical Association affidavit)
- Dr. Barney Honath — Practice: Orthopedic Surgery. No ER coverage; no malpractice insurance. (Florida Medical Association affidavit)
- Dr. Zuzana Hrdlicka — Practice: Ophthalmology. Is working part time now. Is fellowship trained in surgery but not doing it—can't afford insurance. (Florida Medical Association affidavit)
- Dr. David S. Margolis — Practice: General Surgery. Will be practicing without malpractice insurance as of January due to unaffordability. (Florida Medical Association affidavit)
- Dr. Alex J. Marti — Practice: Diagnostic Radiology. Recruiting difficulties; group has had to self-insure due to high premiums. (Florida Medical Association affidavit)
- Dr. Gary S. Lehr — Practice: General Surgery. Will no longer do high-risk laparoscopy surgeries, and won't work with uninsured doctors. (Florida Medical Association affidavit)
- Dr. Jack Harari — Practice: Emergency Medicine. Neurosurgeons all resigned from staff. No neurosurgical capabilities. Patients in need of neurosurgical services are transferred. Delays can be detrimental to patient outcomes. Lost most of neurologists and unable to secure remaining neurologists quickly. Treatment for a patient suffering with an acute ischemic stroke is administration of thrombolytic medication within the initial 3 hours of symptom onset. Per established guidelines a stroke team, which includes a neurologist, should make a determination as to administration of this medication. Inability to obtain rapid neurological consultation has hobbled our ability to administer this treatment. Past 2 years, lost many of our hand surgeons and some remaining have voiced their intention to drop hand

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privileges. Patients may wait for hours, increasing the chance for bad outcomes. Lack of specialists causes the ED physician to expend time finding a specialist to care for the patient and/or arranging for the transfer of the patient. While the physician is focused with this, he is delayed in attending other patients in the ED. Specialties affected: Specialties affected: Cardiology, Emergency Medicine, General Surgery, Hand Surgery, Neurology, Oral/Maxillo Facial Surgery, Orthopedics, Pediatrics/Pediatric Surgery, Radiology, Urology, Vascular Surgery. (Florida Medical Association affidavit)

- Dr. Robert J. Catanzaro — Practice: Orthopaedic Surgery. No high-risk patients, trauma, children, multiply operated patients, highly complicated, litigious patients. (Florida Medical Association affidavit)
- Dr. Richard Ott — Practice: Plastic/Reconstructive Surgery. Will operate on children in other countries but not in Florida—no faith in civil liability system. (Florida Medical Association affidavit)
- Dr. William C. Early — Practice: Hematology/Oncology/Internal. Will no longer do internal medicine—only hematology and oncology. (Florida Medical Association affidavit)

Charlotte County

- At least 32 Charlotte County doctors have recently either curtailed parts of the practices, retired early or quit their practices to take jobs in other states. (*Charlotte Sun-Herald*, July 10, 2003)
- Charlotte County's only two neurosurgeons have cut services at Charlotte Regional Medical Center leaving no neurosurgeon to back up other neurologists in treating stoke or other victims at the hospital. (*Charlotte Sun-Herald*, June 10, 2003)
- Bon Secours-St. Joseph Hospital closed its cardiac and pulmonary monitoring program conducted out of the Cultural Center of Charlotte County. (Bon Secours St. Joseph Hospital, July 2003, FHA Survey)
- Radiologist Dr. Eric Raymond at Bon Secours-St. Joseph Hospital moved his practice to California at the end of May. (*Charlotte Sun-Herald*, May 14, 2003)
- Dr. Ruben Guzman gave up his obstetrics practice even though he never had to pay a claim. (*Charlotte Sun-Herald*, May 30, 2003)
- Eight county physicians left their practices in recent months, including a surgeon, an emergency room doctor, an anesthesiologist and an OB-GYN. (*Charlotte Sun-Herald*, May 30, 2003)
- The number of obstetricians delivering babies in Charlotte dropped from eight to six. Another ob-gyn announced his intent not to renew his OB privileges in the fall when his insurance is up for renewal, also due to malpractice, so physicians delivering babies will be down to 5 or less by the end of the year. (Fawcett Memorial Hospital, July 2003, FHA Survey)

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- Three surgeons dropped privileges at one of the three county hospitals because they could not take the added liability of ER call at all three hospitals. (Fawcett Memorial Hospital, July 2003, FHA Survey)
- Two general surgeons took a leave of absence at another county hospitals for the same reason. (Fawcett Memorial Hospital, July 2003, FHA Survey)
- A neurologist is moving to North Carolina due, in part, to malpractice costs. (*Charlotte Sun-Herald*, June 10, 2003)
- Dr. Han Soon Shin, a Port Charlotte anesthesiologist moved to California after practicing in Florida for nearly 20 years. (*Charlotte Sun-Herald*, February 18, 2003)
- Marc A. Melser is a urologist from Port Charlotte whose liability coverage increased 88 percent, from about $13,000 per year to $24,500 per year. He has opted to reduce coverage and the services he provides, and he will no longer provide bladder removals. Patients needing this procedure will now have to go to a university setting. (Dr. Marc A. Melser, January 2003 academic task force report)
- Dr. James Amontree — Practice: Gastroenterology. Stopped performing liver biopsies and is no longer removing colon polyps endoscopically. (Florida Medical Association affidavit)
- Dr. James Bartek — Practice: Vascular Surgery. Stopped nursing home visits. (Florida Medical Association affidavit)
- Dr. Saligrama Bhat — Practice: Internal Medicine. Decreasing nursing home admissions. (Florida Medical Association affidavit)
- Dr. Thomas Ciuitella — Practice: Ophthalmology. Stopped combined cataract glaucoma surgery, pediatric surgery and cosmetic surgery. (Florida Medical Association affidavit)
- Dr. James Forensky — Practice: Anesthesiology. Discharged all chronic pain patients. No longer performs high-risk pain management procedures. (Florida Medical Association affidavit)
- Dr. Eugene Gregush — Practice: OB/GYN. Will discontinue practicing obstetrics as of 12-01-03. (Florida Medical Association affidavit)
- Dr. Lee Gross — Practice: Family Medicine. Stopped nursing home services, will dissolve ER coverage, and restrict pediatric services. (Florida Medical Association affidavit)
- Dr. Beth Liebowitz — Practice: OB/GYN. Stopped OB practice, stopped seeing Medicaid patients, and considering giving up surgery. (Florida Medical Association affidavit)
- Dr. Marc Melser — Practice: Urology. No longer go to nursing homes. (Florida Medical Association affidavit)

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- Dr. George Nackley — Practice: Internal Medicine. No longer seeing nursing home patients, and has decreased the number of hospitals of which to admit. (Florida Medical Association affidavit)
- Dr. Ramachandran Rajaram — Practice: Nephrology. Stopped seeing high-risk and liabilities. (Florida Medical Association affidavit)
- Dr. Howard Saslow — Practice: Orthopedic Surgery. Has stopped taking emergency room call at 2 hospitals. (Florida Medical Association affidavit)
- Dr. Stephanie Shell — Practice: Family Practice. Has chosen not to see nursing home patients in this state and is considering giving up hospital privileges in the future to decrease liability. (Florida Medical Association affidavit)
- Dr. Steven Shell — Practice: Family Practice. No longer performs OB or does any type of nursing home work. No longer performs newborn exams. No longer provides the community school physical exams for fear of litigation. (Florida Medical Association affidavit)
- Dr. Michael Stampar — Practice: ENT. Has personally seen frivolous lawsuits destroy physician-patient relations. Stopped all cosmetic surgery. Doesn't touch anything but the simplest cases. Will get into healthcare-related business ASAP. (Florida Medical Association affidavit)
- Dr. Peter Dayton — Practice: OB/GYN. Refers high-risk patients to West Palm Beach, and limits the acceptance of patients. (Florida Medical Association affidavit)
- Dr. Teresita C. DeLara — Practice: Endocrinology/Internal Medicine. Limited practice and considering closing it. (Florida Medical Association affidavit)
- Dr. Jose Domingo — Practice: OB/GYN. Limited OB patients to low or no risk; no surgery for high-risk patients; considering early retirement. (Florida Medical Association affidavit)
- Dr. John Moenning — Practice: General Surgery. No longer does ER call. Avoids doing children's cases, and avoids major procedures. (Florida Medical Association affidavit)
- Dr. Steve Moenning — Practice: Colon/Rectal Surgery. No pancreatic surgery. (Florida Medical Association affidavit)
- Dr. George Nackley — Practice: Internal Medicine. No longer sees nursing home patients, and has decreased the number of hospitals to admit patients to. (Florida Medical Association affidavit)
- Dr. Ramachandran Rajaram — Practice: Nephrology. Stopped seeing high-risk and liabilities. (Florida Medical Association affidavit)
- Dr. Howard Saslow — Practice: Orthopedic Surgery. Has stopped taking emergency room call at the 2 hospitals where he is on staff. (Florida Medical Association affidavit)

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- Dr. Jaime Torner — Practice: Internal Medicine. Discontinued nursing homes. Does not perform procedures on high-risk patients. Stopped seeing high-risk (Medicaid, uninsured) at the office. Planning to retire within one year instead of cutting down practice as initially planned. (Florida Medical Association affidavit)
- Dr. Michael C. Heagney — Practice: Radiology. Has given notice to retire & will retire in next 3-4 months. (Florida Medical Association affidavit)
- Dr. Numa J. Tamayo — Practice: IM-Endocrinology. Plans to limit practice to endocrinology only, and is limiting nursing home privileges from 3 –1. (Florida Medical Association affidavit)
- Dr. Victor D. Howard — Practice: Cardiology. Has stopped seeing uninsured, Medicaid & most HMO patients. (Florida Medical Association affidavit)
- Dr. Kevin DeSantis — Practice: Emergency Medicine. Specialists have left the area or have dropped ER coverage due to high liability and virtually no reimbursement. Specialties affected: General Surgery, Hand Surgery, Neurosurgery, Obstetrics. (Florida Medical Association affidavit)
- Dr. Raymond James — Practice: Emergency Medicine. Local specialists are reluctant to care for high-risk trauma patients; unable to recruit EM physicians, no gastroenterology on call, general surgeons have left the state, leaving behind surgeons reluctant to assume the increased work load and risk; no hand surgery coverage 1 week per month. One of our local EDs has completely lost neurosurgical coverage, causing increased load to our hospital and delaying patient care; Physicians completely dropping OB due to high risks and high malpractice insurance costs; plastic surgeons reducing level of their services. Specialties affected: Emergency Medicine, Gastroenterology, General Surgery, Hand Surgery, Neurosurgery, Obstetrics, Plastic Surgery. (Florida Medical Association affidavit)
- Dr. Pedro Perez — Practice: Emergency Medicine. Alternate weekends of no hand surgery, neurosurgery and general surgery. Some patients must be sent over 50 miles away to get needed services. Specialties affected: General Surgery, Hand Surgery, Neurosurgery, Obstetrics. (Florida Medical Association affidavit)
- Dr. Samuel Williams — Practice: Emergency Medicine. Physicians reluctant to take ER call, no gastroenterology call, lost 1 week of coverage of hand per month, decreased neurosurgical coverage; local OB's completely dropping OB portion of their practices; ophthalmologists considering dropping hospital privileges in order to avoid ER call; decreased plastic surgery call (stopped helping with hand injuries), trauma care strained both at our hospitals and in the trauma centers we refer to. Patients are already suffering due to this crisis, but it will get worse unless there is some protection for physicians caring for emergencies. Specialties affected: Emergency Medicine, Gastroenterology, General Surgery, Hand Surgery, Neurosurgery, Obstetrics, Ophthalmology, Plastic Surgery. (Florida Medical Association affidavit)
- Dr. Gary Wright — Practice: Emergency Medicine. Few specialists willing to see ED patients because of the increased liability. Specialties affected: Burns, Emergency Medicine, General Surgery, Gynecology, Hand Surgery, Neurosurgery, Obstetrics,

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Orthopedics, Pediatrics/Pediatric Surgery, Plastic Surgery, Psychiatry, Radiology. (Florida Medical Association affidavit)

Collier County

- No pediatric neurosurgeons are available to treat children under 18. As a result, children with serious head injuries must be transported to Fort Myers or Tampa. (Dr. Frank Schwerin, testimony, January 2003 academic task force report)
- Specialty coverage for emergency and/or trauma care has compromised the provision of emergency/trauma care in the following specialty areas: General Surgery, Hand Surgery. (Florida College of Emergency Physicians affidavit)
- Reporting emergency physician indicates that three general surgeons have left. (Florida College of Emergency Physicians affidavit)
- Reporting emergency physician indicates that most serious hand cases must be transferred to Miami. (Florida College of Emergency Physicians affidavit)
- Reporting emergency physician indicates that the trauma center at Lee Memorial Hospital is threatening to close. (Florida College of Emergency Physicians affidavit)
- There are multiple problems finding general or hand surgical coverage. (Florida College of Emergency Physicians affidavit)
- None of the specialties (general surgery, hand surgery, or intensivists) choose to cover for any trauma patients in the affected hospital emergency department. (Florida College of Emergency Physicians affidavit)
- Dr. Silvia Garcia, a dermatologist, received a 125 percent insurance rate increase and much purchase nearly $12,000 in tail insurance. She has dropped risky procedures such as skin surgeries and flaps and grafts. She notes that if other dermatologists follow suit, such procedures will be unavailable in the county. (Dr. Silvia Garcia, January 2003 academic task force report)
- Dr. Douglas Shepard is a neurologist from Naples. Although no claims have been made against him, his rates have increased to the point where he will be going with minimum coverage to maintain hospital privileges. (Dr. Douglas Shepard, January 2003 academic task force report)
- Dr. Thomas Beckett — Practice: Obstetrics. Stopped seeing Medicare-aged patients and stopped prescribing certain cardiovascular medications. (Florida Medical Association affidavit)
- Dr. Luciano Boemi — Practice: Plastic Surgery. Considering moving practice to Rome and has stopped performing high-risk procedures. (Florida Medical Association affidavit)
- Dr. Luis Bonet — Practice: Cardiology. No longer performs invasive procedures, and is no longer practicing internal medicine. (Florida Medical Association affidavit)

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- Dr. James Boorstin — Practice: Psychiatry. Only one in county that sees Medicaid and indigent patients. (Florida Medical Association affidavit)
- Dr. John Diaz — Practice: Family Practice. Stopped ER coverage for hospital and has stopped delivering babies, and performing vasectomies. (Florida Medical Association affidavit)
- Dr. Kenneth Fields — Practice: Dermatology. Does not treat children. (Florida Medical Association affidavit)
- Dr. Michael Hauig — Practice: Orthopedic Surgery. Refers patients to university. (Florida Medical Association affidavit)
- Dr. Carl Liebert — Practice: General Surgery. Stopped all vascular work, breast surgery, and high-risk procedures. (Florida Medical Association affidavit)
- Dr. Wallace McLean — Practice: OB/GYN. Stopped seeing high-risk OB and cancer patients. (Florida Medical Association affidavit)
- Dr. Leonard Mogelvang — Practice: Plastic/Reconstructive Surgery. Provides no more ER coverage, treats no more burns, cleft lip and palate, or hand fractures. (Florida Medical Association affidavit)
- Dr. David Ritter — Practice: General Surgery. Has taken leave of absence, not covering ER. (Florida Medical Association affidavit)
- Dr. Stephen Thompson — Practice: OB/GYN. Has withdrawn from Medicare. (Florida Medical Association affidavit)
- Dr. Francis Schwerin — Practice: Cardiology. No longer takes ER call. Practice is limited to cardiac testing. Continues to care for less than 5 patients. (Florida Medical Association affidavit)
- Dr. Jon Steohmeyer — Practice: Facial Plastic Surgery. Stopped seeing new patients. (Florida Medical Association affidavit)
- Dr. Armand Cohn — Practice: Internal Medicine. No longer sees pulmonary patients or performs risky diagnostic procedures. (Florida Medical Association affidavit)
- Dr. Pavan Arand — Practice: Internal Medicine. Stopped ER calls. (Florida Medical Association affidavit)
- Dr. Richard Faro — Practice: Cardiac Surgery. Resigned from ER coverage at 2 hospitals, and transfers care of high-risk patients. (Florida Medical Association affidavit)
- Dr. Daniel Morris — Practice: Oncology/Hematology. Asks surgeons not to refer breast cancer patients to him, and refers out patients with acute leukemia. (Florida Medical Association affidavit)

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- Dr. C. Richard Underwood — Practice: General Practice. Not seeing high-risk patients, and has given up emergency room call. (Florida Medical Association affidavit)

Lee County

- Lehigh Regional Medical Center eliminated its obstetrical unit. *(Fort Myers News-Press*, March 25, 2003)
- Dr. Hansel Adkins — Practice: Geriatrics/Family. No longer functions as medical director because FPIT will not give coverage. (Florida Medical Association affidavit)
- Dr. Richard Davis — Practice: Ophthalmology. Stopped performing high-risk glaucoma and cataract procedures. (Florida Medical Association affidavit)
- Dr. Edward Dupay — Practice: Orthopedic Surgery. Reduced ER on-call time. Now practicing defensive medicine. (Florida Medical Association affidavit)
- Dr. Roberto Martinez — Practice: Orthopedic Surgery. No longer accepts high-risk, back, MVA, or workers compensation cases. (Florida Medical Association affidavit)
- Dr. Donald Moyer — Practice: Neurosurgery. Stopped performing cerebral aneurysm surgeries, except in acute emergencies. (Florida Medical Association affidavit)
- Dr. Richard Murray — Practice: OB/GYN. Stopped treating high-risk pregnancies, UBAC, triplets. (Florida Medical Association affidavit)
- Dr. Olga Freeman — Practice: Internal Medicine. Will consider leaving the state of Florida. (Florida Medical Association affidavit)
- Dr. Michael Rosenberg — Practice: General Surgery. No children, no vascular, no advanced laparoscopy procedures. (Florida Medical Association affidavit)
- Dr. Dean Tratger — Practice: Family Practice. Has stopped doing any prenatal care and has stopped treating children under 1 year of age. No longer deliver babies. (Florida Medical Association affidavit)
- Dr. Rachid Aouchiche — Practice: Ophthalmology/Neuro-Ophth. Stopped worker's comp & high-risk ophthalmic surgical procedures. (Florida Medical Association affidavit)
- Dr. Paul DeLeeuw — Practice: Anesthesia. Left hospital practice in Dade to move to Lee County ambulatory surgery. (Florida Medical Association affidavit)
- Dr. Paul Joslyn — Practice: OB/GYN. Stopped doing high-risk OB procedures, and certain high-risk surgical procedures. (Florida Medical Association affidavit)
- Dr. Frank Loh — Practice: Neurology. Considering closing office in December, when malpractice insurance runs up. (Florida Medical Association affidavit)
- Dr. George Markovich — Practice: Orthopedics. No longer treating complex trauma cases, and no pediatric orthopedics. (Florida Medical Association affidavit)

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- Dr. Hansel Adkins — Practice: Geriatrics/Family. Cannot function as Medical Director because FPIT will not give coverage for directors. (Florida Medical Association affidavit)
- Dr. Richard Davis — Practice: Ophthalmology. Stopped doing high-risk glaucoma and cataract procedures. (Florida Medical Association affidavit)
- Dr. Edward Dupay — Practice: Orthopedic Surgery. Reduced ER on call time, and is practicing defensive medicine. (Florida Medical Association affidavit)
- Dr. Scott Geller — Practice: Ophthalmology. Will no longer treat complicated cases with poor prognoses. (Florida Medical Association affidavit)
- Dr. Larry Hobbs — Practice: Emergency Medicine. Must transfer burns to Tampa. Difficulty hiring emergency physicians due to malpractice environment. No available gynecology, obstetrics, pediatrics/pediatric surgery, or psychiatry. Limited availability of gastroenterology, internal medicine, vascular surgery, and dermatology. Many specialists left hospital staff to join staff at sovereign immunity hospital in community—to avoid excessive exposure to liability. Specialties affected: Burns, Emergency Medicine, Gastroenterology, Gynecology, Obstetrics, Pediatrics/Pediatric Surgery, Psychiatry, Trauma Care Center, Dermatology. (Florida Medical Association affidavit)
- Dr. Thomas Schaar — Practice: Emergency Medicine. Our local ability to get a vascular or cardiovascular surgeon to treat a dissecting or ruptured throracolumar aneurysm has disappeared due to high liability over the past 18 months. We now refer these extremely critical patients out of state for repair. Recruiting emergency physicians in Florida has been much more difficult over the past 12 months. I was unable to fill a vacancy for 12 months. In addition, the discrepancy in the cost of malpractice insurance for emergency physicians working for hospitals with sovereign immunity versus those without sovereign immunity has created a serious disadvantage in the ability of the non-sovereign immunity groups, such as ourselves, to recruit and maintain emergency medical staff. The increase in malpractice premium has left fewer dollars for salaries. As we are competing for doctors on a national level, we can offer either fewer hours or less money. Either way, the final outcome is more limited access to patients. Practically, this results in longer waits for patients and increased workloads for physicians. Specialties affected: Cardiology, Cardiovascular Surgery, Emergency Medicine, Gastroenterology, Thoracic Surgery, Vascular Surgery. (Florida Medical Association affidavit)

Martin County

- Martin Memorial Medical Center's chief surgeon was considering a job offer in Louisiana despite never being sued. (*Stuart News*, April 27, 2003)
- Two obstetricians of Women's Health Specialists in Stuart left the state and a third is considering moving. (*Stuart News*, April 27, 2003)

Miami-Dade County

- Aventura Hospital & Medical Center eliminated its obstetrical unit. (Aventura Hospital & Medical Center, January 2003, FHA Survey)

* This report was last updated on August 11, 2003

- Miami Children's Hospital is working on solutions to providing care to children from outside of county who are seeking routine orthopedic care at Miami Children's due to access issues in their own communities. (Miami Children's Hospital, July 2003, FHA Survey)
- Specialty coverage for emergency and/or trauma care has compromised the provision of emergency/trauma care in the following specialty areas: Cardiology, Cardiac Surgery, Emergency Medicine, General Surgery, Hand Surgery, Neurosurgery, Obstetrics, Oral/Maxillo Facial Surgery, Orthopedics, Otolaryngology, Psychiatric, Radiology, Thoracic Surgery, Vascular Surgery. (Florida College of Emergency Physicians affidavit)
- Reporting emergency physician indicates that the hospital where he practices has eliminated the on call neurosurgery coverage in the emergency department. Patients are transferred to another hospital. (Florida College of Emergency Physicians affidavit)
- Reporting emergency physician indicates that, at the affected hospital, otolaryngologists have not taken ER call for the past few years because they do not want to take the liability of ER patients. (Florida College of Emergency Physicians affidavit)
- Reporting emergency physician indicates that three orthopedic surgeons have dropped privileges at the affected hospital because they cannot add the liability of ER calls. There is only one orthopedic physician that covers only one week of the month. During the remaining three weeks of each month, patients must be transferred to other facilities. (Florida College of Emergency Physicians affidavit)
- Reporting emergency physician indicates that many facilities have faced decreased staffing of emergency physicians due to the escalating cost of malpractice premiums. (Florida College of Emergency Physicians affidavit)
- Reporting emergency physician indicates that several Dade County hospitals are having difficulty with availability of hand surgeons for emergency call. The emergency physician understands that existing practices or facilities have had difficulty recruiting hand surgeons. (Florida College of Emergency Physicians affidavit)
- Reporting emergency physician indicates that Mount Sinai Hospital has been required to contract with one physician to provide obstetric care. All other obstetricians refuse. Many physicians have left OB practice. (Florida College of Emergency Physicians affidavit)
- Reporting emergency physician indicates that there are problems obtaining radiology services at several Dade County hospitals. Many radiologists have retired, left the state, or moved practices to diagnostic centers. (Florida College of Emergency Physicians affidavit)
- Reporting emergency physician indicates that thoracic surgeons refuse high-risk patients, directing the emergency department to transfer patients to other facilities. (Florida College of Emergency Physicians affidavit)

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- Reporting emergency physician indicates that emergency physician staffing cannot increase despite any increased patient volume. (Florida College of Emergency Physicians affidavit)
- Reporting emergency physician indicates that staff specialty physicians drop off emergency call or completely drop staff privileges. Such physicians indicate: "all my risk is through the ER." (Florida College of Emergency Physicians affidavit)
- Reporting emergency physician indicates that staff physicians in key specialties are moving or are retiring early. New physicians cannot be recruited into practices. (Florida College of Emergency Physicians affidavit)
- Dr. Douglas Slotkoff of Miami has cared for developmentally disabled children and adults at Sunrise Communities in South Miami for eight years. This year may be his last because of rising medical liability rates. (Dr. Douglas Slotkoff, January 2003 academic task force report)
- Change in practice: Dr. Jerrold Young has limited his elective cases and has stopped taking ER calls and doing emergency cases. Dr. Elizabeth Etkin Kramer has stopped delivering babies. Dr. Carlos E. Stincer has stopped seeing ER patients, suicidal or any high-risk patient. (Dade County Medical Association, July 3, 2003)
- Retired / Moved: Drs. Desiree and Luis A. Reina left Florida; Dr. Roger Moebus, Dr. Karl Smiley and Dr. David Diaz have retired or left the area or stopped doing high risk surgery. (Dade County Medical Association, July 3, 2003)
- Dr. Wilfredo Amaya — Practice: Orthopedic Surgery. No longer performing revision joint replacements; referring patients to trauma centers. (Florida Medical Association affidavit)
- Dr. Stephen Blythe — Practice: Orthopedic Surgery. Stopped seeing pregnant women and worker's compensation patients. Stopped hospital ER coverage, and might retire. (Florida Medical Association affidavit)
- Dr. Jose M. Delgado, Jr. — Practice: Internal Medicine. No longer provides ER care and will have no insurance coverage as of Oct. 2003. (Florida Medical Association affidavit)
- Dr. Ranley Desir — Practice: Cardiovascular Disease. Resigned from ER coverage at Cedars hospital. (Florida Medical Association affidavit)
- Dr. Orlando Arana — Practice: General Practice. Stopped performing general surgeries, works on a part-time basis, and doesn't carry insurance. (Florida Medical Association affidavit)
- Dr. Shaughn Bennett — Practice: Family Practice. No longer performing office procedures or seeing problem-patients, and has stopped treating Medicaid patients. (Florida Medical Association affidavit)

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- Dr. Michael Brazda — Practice: Emergency Medicine. Limits high-risk procedures and has changed to practicing defensive medicine. (Florida Medical Association affidavit)
- Dr. Mark Brown — Practice: Orthopedic Surgery. Will not see patients involved in a personal injury or involved with an attorney, and will not see high-risk patients. (Florida Medical Association affidavit)
- Dr. Carlos Buznego — Practice: Ophthalmology. Reduced providing care to high-risk patients. (Florida Medical Association affidavit)
- Dr. Damion Campbell — Practice: Emergency Medicine. Unable to obtain specialist to see patients in the ER. (Florida Medical Association affidavit)
- Dr. Emilio Carullo — Practice: Plastic Surgery. Does not perform high-risk procedures. (Florida Medical Association affidavit)
- Dr. Rufus Joseph — Practice: Pediatrics. Accepts no more CMS patients, and has cut back office practice by 50 percent. Looking into relocation. (Florida Medical Association affidavit)
- Dr. Rafael Fernandez — Practice: Orthopedic Surgery. Limited hand complaints taken. No new trauma patients. (Florida Medical Association affidavit)
- Dr. Joyce Fleites — Practice: Internal Medicine. Avoids ER calls, high-risk procedures, and won't see patients that aren't a part of their practice. (Florida Medical Association affidavit)
- Dr. Felix Freshwater — Practice: Reconstructive Plastic Surgery. No longer treats facial fractures, and no longer performs post-mastectomy breast reconstruction procedures. (Florida Medical Association affidavit)
- Dr. Juan Garcia — Practice: Cardiology. Stopped treating high-risk PCI and unassigned ER patients. (Florida Medical Association affidavit)
- Dr. Richard Glatzer — Practice: Orthopedic Surgery. Stopped performing all surgeries. (Florida Medical Association affidavit)
- Dr. David Keyes — Practice: Orthopedic Surgery. Cut back on trauma and high-risk areas, and has limited ER calls. (Florida Medical Association affidavit)
- Dr. Victor Krestew — Practice: Family Practice. Stopped performing minor office surgery. (Florida Medical Association affidavit)
- Dr. Jay Levine — Practice: Clinical Cardiology. Stopped treating unassigned ER and uninsured patients. (Florida Medical Association affidavit)
- Dr. Richard Levitt — Practice: Orthopedic Surgery. No longer treats spine disorders, performs ER work, or takes on high-risk cases. (Florida Medical Association affidavit)

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- Dr. Eduardo Martinez — Practice: Pulmonary Medicine. No longer providing services to OB patients. (Florida Medical Association affidavit)
- Dr. Ralph Nader — Practice: Cardiology. Stopped seeing unassigned ER patients, and has stopped performing high-risk procedures. (Florida Medical Association affidavit)
- Dr. David Nateman — Practice: Emergency Medicine. Unable to obtain specialists to see patients in the ER. (Florida Medical Association affidavit)
- Dr. Harry Nateman — Practice: Emergency Medicine. Must practice defensive medicine. (Florida Medical Association affidavit)
- Dr. Aizik Wolf — Practice: Neurosurgery. Will be moving if something is not done. Does not handle cases that involve possible lawsuits. (Florida Medical Association affidavit)
- Dr. Angel Tejeda — Practice: Nephrology. No longer providing services to OB patients. (Florida Medical Association affidavit)
- Dr. Charles Shanker — Practice: Internal Medicine. Will not do invasive procedures and avoids ER consulting, and OB patients. (Florida Medical Association affidavit)
- Dr. Wayne Pollak — Practice: Clinical Cardiology. Stopped seeing unassigned ER patients, and patients that are uninsured. (Florida Medical Association affidavit)
- Dr. Jacqueline Redondo — Practice: Hand Surgery. Stopped carrying insurance, stopped seeing high-risk patients, stopped workers comp. (Florida Medical Association affidavit)
- Dr. Jeffrey Rich — Practice: Orthopedic Surgery. Doesn't do difficult fracture cases or difficult revision surgeries. (Florida Medical Association affidavit)
- Dr. Robert Rudas — Practice: Emergency Medicine. Must practice defensive medicine. (Florida Medical Association affidavit)
- Dr. Richard Sandrow — Practice: Orthopedic Surgery. Stopped surgery entirely in Dec 2002. Premium increased 200% in 2 years. Never had a suit in 32 years of practice. Could no longer afford insurance. (Florida Medical Association affidavit)
- Dr. Ralph Slonim — Practice: Internal Medicine. Quit. (Florida Medical Association affidavit)
- Dr. Roberta Slonim — Practice: Internal Medicine. Avoiding high-risk patients and has stopped doing procedures that she is well trained for out of fear; also refusing new patients. (Florida Medical Association affidavit)
- Dr. Henry Storper — Practice: Psychiatry. Reduced hospital practice. (Florida Medical Association affidavit)

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- Dr. Jorge Acevedo — Practice: Internal Medicine. Reimbursement is too low to cover the cost of higher insurance. (Florida Medical Association affidavit)
- Dr. Luis Caceres — Practice: Internal Medicine. No longer participates in ER calls. (Florida Medical Association affidavit)
- Dr. Marc Csete — Practice: Pulmonary Critical Care. Will soon stop seeing HMO patients, if forced to "go bare" without insurance. (Florida Medical Association affidavit)
- Dr. Carlos DeCespedes — Practice: OB/GYN. Referring all high-risk patients to the University. (Florida Medical Association affidavit)
- Dr. Eduardo Barroso — Practice: Plastic/Reconstructive Surgery. Dropped nearly all ER calls. (Florida Medical Association affidavit)
- Dr. Eddie G. Canto — Practice: Cardiology. Restricted complicated cardiac cases, and diminished income from managed care. (Florida Medical Association affidavit)
- Dr. Ramiro Coro — Practice: General Practice. Stopped high-risk procedures & seeing certain patients—no mal practice insurance—can't afford. (Florida Medical Association affidavit)
- Dr. Adrian Del Boca — Practice: OB/GYN. Reduced procedures to low-risk, can't find specialists to see patients with complications. (Florida Medical Association affidavit)
- Dr. Myron Tanenbaum — Practice: Ophthalmology. Very difficult cases such as emergency room traumas and advanced cancer cases that have a high risk for poor outcomes which has a high risk for lawsuits. (Florida Medical Association affidavit)
- Dr. Angel Tedeja — Practice: Nephrology. No longer providing services to OB patients. (Florida Medical Association affidavit)
- Dr. Aizik Wolf — Practice: Neurosurgery. Will be moving if something is not done. Does not accept cases that involve a possible lawsuit. (Florida Medical Association affidavit)
- Dr. Abdul Agha — Practice: Cardiology. Has gone to part-time practice to reduce insurance premium. (Florida Medical Association affidavit)
- Dr. Edward Cutler — Practice: Internal Medicine. Reduced practice to part-time. (Florida Medical Association affidavit)
- Dr. Rufus Joseph — Practice: Pediatrics. No more CMS patients, and cut back office practice by 50%. Looking into relocation. (Florida Medical Association affidavit)
- Dr. Beatriz Amendola — Practice: Radiology. Not seeing high-risk patients. (Florida Medical Association affidavit)

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- Dr. Mansura Barkett — Practice: Internal Medicine. Stopped going to nursing homes. (Florida Medical Association affidavit)
- Dr. Ignacio J. Calvo — Practice: Orthopaedic Surgery. Does not perform surgery on Medicaid patients, only does simple hand surgery procedures. (Florida Medical Association affidavit)
- Dr. Andres Cowley — Practice: Gastroenterology. No longer admits patients to hospital to avoid exposure to high risk. (Florida Medical Association affidavit)
- Dr. Candido Diaz-Cruz — Practice: Cardiology/Internal Med. Cancelled ER on call, curtailed consults on pregnant patients, and only cares for patients over 55. (Florida Medical Association affidavit)
- Dr. Ron Joseph — Practice: Radiology. Stopped seeing certain types of patients and high-risk cases. (Florida Medical Association affidavit)
- Dr. Marilyn Marcus — Practice: General Practice. Considering early retirement. Can't give staff raises, and has suffered emotional and financial stress. (Florida Medical Association affidavit)
- Dr. Julian Marquez — Practice: General Practice. High-risk procedures are referred to specialists, and patients' age restricted to 10 years or older. (Florida Medical Association affidavit)
- Dr. Diedre Marshall — Practice: Plastic Surgery. Considering leaving the state. (Florida Medical Association affidavit)
- Dr. Alvaro Martinez — Practice: Cardiology. Restricted to ECG interpretation and teaching rounds at UM. (Florida Medical Association affidavit)
- Dr. Juvinal Martinez — Practice: Family Practice. Stopped doing any risky procedures. (Florida Medical Association affidavit)
- Dr. Marisa Messore — Practice: OB/GYN. No longer practices OB. (Florida Medical Association affidavit)
- Dr. Donald Minervini — Practice: General/Vascular Surgery. No longer does high-risk procedures. (Florida Medical Association affidavit)
- Dr. Jaime Navarro — Practice: Oral/Maxillofacial Surgery. Does not perform orthognathic or temporary mandibular joint surgeries, or treat ER patients. (Florida Medical Association affidavit)
- Dr. Denis Neuhut — Practice: Gastroenterology. No longer performs biliary procedures with biliary stenting and sphincterotomies. (Florida Medical Association affidavit)
- Dr. Linda Pao — Practice: Neurology. No longer seeking ER patients, and won't see high-risk patients. (Florida Medical Association affidavit)

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- Dr. Allaaddin Mollabashy — Practice: Orthopedic Surgery. Moved to Indiana; they have had tort reform for nearly 30 years. (Florida Medical Association affidavit)
- Dr. Juan B. Ojeda — Practice: Family Practice. Stopped doing minor procedures such as lacerations, minor surgeries… due to crisis. (Florida Medical Association affidavit)
- Dr. Mel T. Ortega — Practice: Plastic Surgery. No longer performs more complex reconstructive procedures. (Florida Medical Association affidavit)
- Dr. Jose R. Pinero — Practice: Cardiology. Stopped seeing OB cases with heart disease due to high-risk of litigation. (Florida Medical Association affidavit)
- Dr. Jose E. Portuondo — Practice: Emergency Med/Critical. Curtailed critical care to 1/3 of what it was before. Is working part-time out of state, and will leave in 1 year. (Florida Medical Association affidavit)
- Dr. Leonard M. Toonkel — Practice: Radiation Oncology. No longer sees or treats children with cancer. (Florida Medical Association affidavit)
- Dr. Jose L. Ruiz — Practice: Family Practice. Stopped doing minor surgery. (Florida Medical Association affidavit)
- Dr. Ruth C. Schobel — Practice: Pediatrics. No longer attends newborn deliveries or provides ER care for her patients. (Florida Medical Association affidavit)
- Dr. Alberto Alea — Practice: Infectious Disease. Tried to stop seeing ER admissions, and has stopped seeing pregnant women or young patients. (Florida Medical Association affidavit)
- Dr. Efrain Camara — Practice: Gastroenterology/Internal Medicine. Had to stop seeing uninsured patients, and is considering retiring from practice earlier than anticipated. (Florida Medical Association affidavit)
- Dr. Misael Gonzalez — Practice: Family Medicine. Is referring high-risk patients to other physicians. (Florida Medical Association affidavit)
- Dr. Huberto E. Merayo — Practice: Psychiatry. Has stopped seeing patients in nursing homes & homes due to high-risk. (Florida Medical Association affidavit)
- Dr. Ofer Rodriguez — Practice: Plastic Surgery. Avoids dealing with reconstructive surgery patients. (Florida Medical Association affidavit)
- Dr. Grissel MacWilliams — Practice: Internal Medicine. No ER call, no more office surgical procedures, and will stop admitting patients to hospital. (Florida Medical Association affidavit)
- Dr. Gust Martinez-Padilla — Practice: Internal Medicine. No ER patients. (Florida Medical Association affidavit)

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- Dr. Alvaro I. Martinez — Practice: Cardiology. Has stopped seeing OB/GYN cases. (Florida Medical Association affidavit)
- Dr. Richard Tannenbaum — Practice: Cardiology. No pregnant women or ER call. (Florida Medical Association affidavit)
- Dr. Eduardo Safille — Practice: Internal Medicine. Stopped taking new cases from ER-admissions. (Florida Medical Association affidavit)

Monroe County

- Two Key West orthopedic surgeons took a leave of absence, leaving Lower Florida Keys Medical Center without any on-call orthopedic surgeons in the emergency room. Both have temporarily returned until the Legislature decides on the issue. (*Associated Press*, May 23, 2003)
- Dr. Robert Cantana — Practice: Orthopedic Surgeon. Not performing spine surgeries and has stopped seeing indigent patients. (Florida Medical Association affidavit)
- Dr. David Perry — Practice: Orthopedic Surgery. No spine surgery, and intends to leave state within 1 year if malpractice rates increase. (Florida Medical Association affidavit)
- Dr. Ronald Sarness — Practice: Family Practice. No longer provides inpatient hospital care. (Florida Medical Association affidavit)
- Dr. Joseph Scarlett — Practice: General Surgery. Moving out of state September 10. Malpractice insurance is too expensive to justify any high-risk procedures or even moderate risk. (Florida Medical Association affidavit)
- Dr. Richard Earl Brown — Practice: Gastroenterology. Self-insured, can't afford traditional insurance. (Florida Medical Association affidavit)
- Dr. Jesse Peurifoy — Practice: General Surgery. Moved to Mississippi. (Florida Medical Association affidavit)

Okeechobee County

- Raulerson Hospital lost two of four general surgeons due to malpractice premiums. Another surgeon is expected to retire in August. The ER no longer has 24/7 coverage and must transfer patients to another hospital. The hospital's radiology group is considering reducing its coverage limits to reduce premiums. Hospitals (Raulerson & Martin Memorial) will have to give group physicians a waiver from the medical staff by-laws. (Raulerson Hospital, July 2003, FHA Survey)

Palm Beach County

- Columbia Hospital eliminated its obstetrics unit, including on-call obstetrical coverage in its emergency department. (Columbia Hospital, July 2003, FHA Survey)
- Palm Beach County's largest physician group – with 51 doctors – which treats more than 50,000 patients annually, stopped treating new hospital patients. (*Palm Beach Post*, May 28, 2003)

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- Seven physicians at Palm Beach Surgical Associates stopped performing non-emergency surgery in June. (*Palm Beach Post*, May 28, 2003)
- Over the past 18 months, 119 doctors in the county have limited or stopped performing various procedures, according to the Palm Beach Medical Society. (*Palm Beach Post*, May 28, 2003)
- 76 physicians have applied for leaves of absence from JFK Medical Center. This includes the 51 physicians from Medical Specialists of the Palm Beaches and Palm Beach Surgical Associates. (*Miami Herald*, May 28, 2003)
- Glades General Hospital is unable to recruit specialists into the area. (Glades General Hospital, July 2003, FHA Survey)
- A seven-member cardiology group applied for leave of absence from Good Samaritan Hospital, JFK Medical Center and St. Mary's Medical Center where they practice. (St. Mary's Medical Center, July 2003, FHA Survey)
- Approximately 20 years ago there were 15 neurosurgeons in Palm Beach County with a population of 500,000 to 600,000. The county now has a population of 1.2 million and there are 11 neurosurgeons. (Columbia Hospital, July 2003, FHA Survey)
- Palm Beach County has only one pediatric neurosurgeon, Dr. Michael Chapparo. (Palms West Hospital, July 2003, Florida Hospital Survey)
- Peter Marmerstein, the CEO of St. Mary's Medical Center in West Palm Beach, operates one of only 11 regional prenatal intensive care centers in the state. These centers serve poor and low-income high-risk obstetrics patients. The physician group providing care at the center is facing a 124.8 percent increase in liability premiums. The group is forced to choose between paying the premium and dropping coverage, which would result in the group ceasing work at the center. (Peter Marmerstein, January 2003 academic task force report)
- Dr. Marcelle G. Habib, a pediatrician who opened his Palm Harbor practice in Palm Harbor practice in early 2001, found his already-high malpractice insurance has increased to the point where it is unaffordable for the year 2003. (Dr. Marcelle G. Habib, January 2003 academic task force report)
- Dr. Carlos J. Vazquez, an OB/GYN in Pinellas County, saw has medical liability insurance skyrocket from $30,000 to $160,000 and had no resort but to liquidate his practice and move to Broward County, where he was permitted to practice without liability insurance. (Dr. Carlos Vazquez, January 2003 academic task force report)
- Dr. Robert Spiegel, a St. Petersburg urologist, has curtailed some services due to concerns about malpractice suits. For the past three years, he was the only urologist treating patients insured by Pinellas County Social Services in the lower-third of Pinellas County. He has resigned as a participant in the plan because of his perception that those patients tended to be more potentially litigious then the population as a whole. (Dr. Robert Spiegel, January 2003 academic task force report)

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- Palm Beach Gardens Hospital's only neurosurgeon can only take calls part of the time, therefore neurological surgical care is void for a couple of weeks a month. (Dr. Cline testimony, January 2003 academic task force report)
- Dr. Leon Abram — Practice: Spine Surgery. Cannot see patients at high-risk for litigation. (Florida Medical Association affidavit)
- Dr. Gary Ackerman — Practice: Orthopedic Surgery. Stopped seeing emergency room patients. (Florida Medical Association affidavit)
- Dr. Fred Altman — Practice: Cardiology. Cancelled malpractice Insurance. (Florida Medical Association affidavit)
- Dr. Armando Armas — Practice: Oncology & Hematology. Had to stop seeing several patients, and stopped providing care to patients with obstetrical emergency complications. (Florida Medical Association affidavit)
- Dr. Jose Arrascue — Practice: Nephrology. No longer performing renal biopsies, and "difficult" patients have been let go. (Florida Medical Association affidavit)
- Dr. Jay Baker — Practice: Cardiology. Stopped ER and resigned from staff at Boca Community Hospital for cardiology. (Florida Medical Association affidavit)
- Dr. Peter Ballas — Practice: Dermatology/Surgery. Stopped performing high-risk surgeries. (Florida Medical Association affidavit)
- Dr. Hilton Becker — Practice: Plastic Surgery. Stopped performing hand surgeries, major reconstructions, and melanoma surgeries. (Florida Medical Association affidavit)
- Dr. Mark Bergman — Practice: Orthopedic Surgery. No longer treats basic pediatric fractures, complicated hip or knee problems. (Florida Medical Association affidavit)
- Dr. Brian Bernick — Practice: OB/GYN. Stopped all elective surgeries. (Florida Medical Association affidavit)
- Dr. Regina Bland — Practice: Pediatrics. No longer see patients in the hospital. (Florida Medical Association affidavit)
- Dr. Robin Braver — Practice: Internal Medicine. Seriously considering moving out of the state, and not treating difficult-case patients. (Florida Medical Association affidavit)
- Dr. Arthur Burdett — Practice: Orthopedic Surgery. Limited practice to hip and knee problems. Spine/hand surgeries and ER calls have been discontinued. (Florida Medical Association affidavit)
- Dr. Roy Cacciaguida — Practice: Internal Medicine. No longer sees patients under the age of 65, and is about to retire early. (Florida Medical Association affidavit)
- Dr. Mariaelena Carabello — Practice: Family Medicine. Closed practice due to liability insurance. (Florida Medical Association affidavit)

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- Dr. Nevin Carp — Practice: Pulmonary Medicine. Stopped insertions of central line catheters and endotracheal intubations. (Florida Medical Association affidavit)
- Dr. Robert Chaitin — Practice: Gynecology. Stopped practicing obstetrics. (Florida Medical Association affidavit)
- Dr. Joseph Chaial — Practice: Orthopedic surgery. Stopped ER and high-risk procedures. (Florida Medical Association affidavit)
- Dr. James Clancy — Practice: Foot/Ankle Reconstruction. Stopped ER calls, and high-risk cases. (Florida Medical Association affidavit)
- Dr. Harvey Cohen — Practice: Gastroenterology. Stopped performing liver and pancreatic biopsies. Will retire if crisis continues. (Florida Medical Association affidavit)
- Dr. Steven Coletti — Practice: Internal Medicine. Limited seeing OR and high-risk patients. (Florida Medical Association affidavit)
- Dr. Edgar Covarrubias — Practice: Cardiology. Considering early retirement, and decreasing hospital practice. (Florida Medical Association affidavit)
- Dr. James Daughtry — Practice: Urology. Will not accept high-risk patients. (Florida Medical Association affidavit)
- Dr. Mitchell Davis — Practice: Gastroenterology. Refuses consults from injured patients; ended agreements with poorer paying insurers. (Florida Medical Association affidavit)
- Dr. Louis Donaghue — Practice: Orthopedic Surgery. No longer performs or assists with surgeries due to high rates. (Florida Medical Association affidavit)
- Dr. J. Roy Duke — Practice: Pulmonary Medicine. Retired from private practice and will work at VA hospital. (Florida Medical Association affidavit)
- Dr. Merrill Epstein — Practice: Psychiatry. Avoiding patients under 65 because of increased risk, fears every new encounter as potential lawsuit. (Florida Medical Association affidavit)
- Dr. Carlos Cowley — Practice: Cardiology. Stopped seeing trauma patients at Delray Hospital. (Florida Medical Association affidavit)
- Dr. Kenneth Mitchell — Practice: Ophthalmology. Reluctant to see high-risk patients, and perform certain high-risk procedures. (Florida Medical Association affidavit)
- Dr. Martin Frisosky — Practice: Otolaryngology. No longer performs surgeries, and has limited hours (after 20 years of practice). (Florida Medical Association affidavit)

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- Dr. David Funt — Practice: Cardiology. Resigned from hospital ER, and will eventually stop all consultative work because of risk. (Florida Medical Association affidavit)
- Dr. Ronald Gabor — Practice: Cardiology. Resigned from hospital because of ER calls, and tries to avoid high-risk OB consultations. (Florida Medical Association affidavit)
- Dr. Robert Gold — Practice: Urology. No longer treats high-risk patients. (Florida Medical Association affidavit)
- Dr. Lawrence Gorfine — Practice: Anesthesiology. Will not perform certain neurolytic block procedures, and will not insert morphine pumps/spinal cord stimulators. (Florida Medical Association affidavit)
- Dr. David Gross — Practice: Psychiatry. Restricted hospital practice, and is specific in patient acceptance. (Florida Medical Association affidavit)
- Dr. Bruce Grossman — Practice: Gastroenterology. Stopped performing risky surgeries. (Florida Medical Association affidavit)
- Dr. Eugene Holly — Practice: Neurological Surgery. Retired as of 3-31-03. (Florida Medical Association affidavit)
- Dr. Carolyn Hauss — Practice: Family Practice. Considering leaving the state after 14 years of practice here because of insurance coverage. (Florida Medical Association affidavit)
- Dr. Jorge Inga — Practice: Family Medicine. Limits hospital and nursing home work. (Florida Medical Association affidavit)
- Dr. Ben Kennedy — Practice: OB/GYN. Stopped OB practice, and stopped performing high-risk gynecological procedures. (Florida Medical Association affidavit)
- Dr. Bhogendra Khanal — Practice: Family Practice. Stopped hospital practice. (Florida Medical Association affidavit)
- Dr. Marvin Kohn — Practice: Otolaryngology. Dropped some ER, and stopped performing high-risk hand surgeries. (Florida Medical Association affidavit)
- Dr. Sheldon Konigsberg — Practice: Gastroenterology. No longer seeing hospitalized patients, and is restricting practice to elective cases only. (Florida Medical Association affidavit)
- Dr. Andrew Ladner — Practice: Internal Medicine. Restricted nursing home primary patient responsibilities. (Florida Medical Association affidavit)
- Dr. Donald Lambe — Practice: Orthopedic Surgery. Stopped taking ER calls. (Florida Medical Association affidavit)

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- Dr. David Laskway — Practice: OB/GYN. Stopped performing high-risk obstetrics and gynecological procedures. (Florida Medical Association affidavit)
- Dr. Miguel Lopez-Viego — Practice: General/Vascular Surgery. Not performing liver surgeries, and is dropping certain aspects of breast cancer care. (Florida Medical Association affidavit)
- Dr. Gene Manko — Practice: OB/GYN. Stopped prenatal testing, performing high-risk surgeries and obstetrics. (Florida Medical Association affidavit)
- Dr. Mitchell Marks — Practice: Internal Medicine. Considering leaving the state. (Florida Medical Association affidavit)
- Dr. John Merey — Practice: Ophthalmology. Ceased performing all eye operations. (Florida Medical Association affidavit)
- Dr. Negar Mohamed — Practice: Internal Medicine. Stopped private practice due to cost of insurance. (Florida Medical Association affidavit)
- Dr. James Murata — Practice: ENT. Has made surgical restrictions, and performs more diagnostic tests. (Florida Medical Association affidavit)
- Dr. Rafael Nunez — Practice: Internal Medicine. Stopped visiting nursing homes. (Florida Medical Association affidavit)
- Dr. Leonard Ostreich — Practice: Gynecology. No longer accepts HMO patients, or performs major surgeries. (Florida Medical Association affidavit)
- Dr. Alan Patterson — Practice: OB/GYN. Stopped doing high-risk OB, stopped doing certain GYN surgeries. (Florida Medical Association affidavit)
- Dr. Mark Pinsky — Practice: Plastic Surgery. Stopped seeing trauma and ER patients. (Florida Medical Association affidavit)
- Dr. Jeffrey Press — Practice: Orthopedic Surgery. Doesn't see neck, hands, back patients due to legal risks; dropped some ER coverage. (Florida Medical Association affidavit)
- Dr. Gerardo Quinonez — Practice: Internal Medicine. Stopped seeing patients who are confrontational or in any way "high-risk." (Florida Medical Association affidavit)
- Dr. Richard Raborn — Practice: Internal Medicine. Preparing to leave practice to start MDVIP practice, then retire early. (Florida Medical Association affidavit)
- Dr. Alexis Renta — Practice: Pain Medicine. Performs no surgical procedures, no high-risk nerve blocks, and provides no charitable care. (Florida Medical Association affidavit)
- Dr. Merrill Reuter — Practice: Orthopedic Surgery. Stopped doing high-risk procedures, and limited amount of hospital and ER calls. (Florida Medical Association affidavit)

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- Dr. Allen Rosen — Practice: Pulmonary/Critical Care. Is currently applying for a license in Texas, and has stopped seeing pregnant and high-risk patients. (Florida Medical Association affidavit)
- Dr. Andrew Ross — Practice: General/Colon/Rectal. Stopped doing sphincter repairs, complex surgeries, and limited ER call. (Florida Medical Association affidavit)
- Dr. Conrad Wynna — Practice: Pediatrics. Resigned hospital privileges. (Florida Medical Association affidavit)
- Dr. Moises Virelles — Practice: OB/GYN. Stopped accepting OB patients as of 7/03. (Florida Medical Association affidavit)
- Dr. Charles Theofilos — Practice: Neurosurgery. No longer performs brain surgery or extremely complex spinal cases. (Florida Medical Association affidavit)
- Dr. Robert Tome — Practice: Family Practice. Stopped admitting patients to hospitals. In process of limiting pediatric practice to children older than 8 years old. Stopped going to nursing homes. (Florida Medical Association affidavit)
- Dr. Aurea Tomeski — Practice: Internal Medicine. Restricted practice and no longer accepts Medicaid patients. (Florida Medical Association affidavit)
- Dr. Mark Schor — Practice: Internal Medicine. Stopped taking emergency room call, does not prescribe pain medication, does not care for obese patients, and does not care for pregnant patients. (Florida Medical Association affidavit)
- Dr. Robert Scoma — Practice: Thoracic Surgery. Stopped seeing high-risk patients in the hospital and ER unless on call. Does not do second opinions. Has stopped certain high-risk procedures. (Florida Medical Association affidavit)
- Dr. Ida Sebastian — Practice: GYN/Related Surgery. Refers high-risk GYN surgery patients to oncology surgeons at the University of Miami. (Florida Medical Association affidavit)
- Dr. Robert Simon — Practice: Orthopedic Surgery. Stopped treating most children. (Florida Medical Association affidavit)
- Dr. James Smith — Practice: Family Practice. No house calls, no school calls, sports medicine physicals for free, stopped hospital care, no risk procedures for complex patients - referred to University. Do not carry malpractice insurance since 11/1/03. (Florida Medical Association affidavit)
- Dr. Richard Sinclair — Practice: OB/GYN. Stopped OB in 1999; retired from private practice 2000. Currently volunteering in GYN service at a migrant clinic. (Florida Medical Association affidavit)
- Dr. Robin Sykes — Practice: Plastic Surgery. Stopped offering procedures to patients in riskier categories (obese, with any medical problems) and has been regularly turning away or discouraging procedures on patients who she feels are

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more likely to sue in case of any type of problem with surgery. (Florida Medical Association affidavit)

- Dr. Gostal Arcelin — Practice: OB/GYN. Practicing without malpractice insurance, and discharging litigious patients. (Florida Medical Association affidavit)
- Dr. Susan Beil — Practice: OB/GYN. Practicing without malpractice insurance. (Florida Medical Association affidavit)
- Dr. Anthony Bufo — Practice: Pediatric/Trauma Surgery. Decreases amount of trauma/ER call, and refers patients with high risk. (Florida Medical Association affidavit)
- Dr. Kenneth Mitchell — Practice: Ophthalmology. Reluctant to certain high-risk patients and procedures. (Florida Medical Association affidavit)
- Dr. G. Clay Baynham — Practice: Spinal Surgery. No more complex elective spinal procedures, and has reduced exposure to patients requiring emergency care. (Florida Medical Association affidavit)
- Dr. Robert Ellis Blais — Practice: Cardio-Thoracic & Vascular. Has transferred high-risk procedures, and has had to cancel malpractice insurance. (Florida Medical Association affidavit)
- Dr. Todd Bradford — Practice: D.O. Doesn't do colpascopies or endometrial biopsies. (Florida Medical Association affidavit)
- Dr. Richard Bregman — Practice: Internal Medicine. Less hospital care, and will probably be forced to retire 5-10 years earlier than planned. (Florida Medical Association affidavit)
- Dr. Mark Bromson — Practice: Orthopaedic Surgery. Reduced indigent care, and eliminated emergency calls and high-risk procedures.
- Dr. Douglas Dedo — Practice: Otolaryngology. Stopped some procedures due to risk, and head and neck cancer patients because of long hospital stays. (Florida Medical Association affidavit)
- Dr. Louis Steven — Practice: Plastic Surgery. Decreased ER call, and performs fewer operations in areas prone to litigation. (Florida Medical Association affidavit)
- Dr. Jr. DeLucia — Practice: Family Practice. Stopped seeing ER call patients from hospital (unassigned), and accepts no acutely sick new patients. (Florida Medical Association affidavit)
- Dr. Robert L. Diaz — Practice: Orthopaedic Surgery. Limiting revision surgery of total hip/knee replacements, high-risk patients. (Florida Medical Association affidavit)

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- Dr. Gary DiBlasio — Practice: Physical Med&Rehab. Restricted types of pain management, and has dropped malpractice insurance—up from $5,000 to $75,000. (Florida Medical Association affidavit)
- Dr. Allen Dinnerstein — Practice: OB/GYN. Stopped high-risk OB, and may drop liability if costs increase. (Florida Medical Association affidavit)
- Dr. Curtis Emmer — Practice: Head/Neck Surg-ENT. Significant number of cases referred out to limit liability exposure. (Florida Medical Association affidavit)
- Dr. Glenn H. Englander — Practice: Gastroenterology/Int Med. Less ER patients (ones he has never met before); can't take internal medicine call in ER.
- Dr. Bart Gatz — Practice: Anesthesiology. No high-risk, Medicaid or charitable care. (Florida Medical Association affidavit)
- Dr. Maged Habib — Practice: Ophthalmology. Avoids certain high-risk eye surgeries. (Florida Medical Association affidavit)
- Dr. Stewart Lewis — Practice: Int. Med. Dropped liability insurance. (Florida Medical Association affidavit)
- Dr. Augusto Lopez-Torres — Practice: G.E. High risks are avoided or referred out.
- Dr. Michael Milstein — Practice: Family Practice. Stopped hospital work, and stopped office surgical procedures. (Florida Medical Association affidavit)
- Dr. Pierre Montrose — Practice: Psychiatry. Stopped seeing severely depressed, high- risk, suicidal patients. (Florida Medical Association affidavit)
- Dr. Morris Nauss — Practice: Gastroenterology. Avoids ERCP, and doesn't carry malpractice insurance. (Florida Medical Association affidavit)
- Dr. Lourdes Nieves — Practice: Pediatrics. Cannot afford to take high-risk patients. (Florida Medical Association affidavit)
- Dr. Daniel Ohara — Practice: Plastic Surgery. Stopped performing procedures of the hand. (Florida Medical Association affidavit)
- Dr. Jose Ortega — Practice: Orthopedic Surgery. Stopped complex fractures where the results may have a bad outcome. (Florida Medical Association affidavit)
- Dr. Colette Brown-Graham — Practice: OB/GYN. Will not see "high-risk" patients due to liability. (Florida Medical Association affidavit)
- Dr. Carlos Cowley — Practice: Cardiology. Stopped seeing trauma patients at Delray Hospital. (Florida Medical Association affidavit)

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- Dr. Lori Ann Ferrara — Practice: OB/GYN. Only practice office gynecology. Has stopped performing OB and surgeries as of 11/02. (Florida Medical Association affidavit)
- Dr. Melissa Friedman — Practice: OB/GYN. Practicing without medical malpractice insurance, and is reducing high-risk patients. (Florida Medical Association affidavit)
- Dr. Samuel Kaufman — Practice: OB/GYN. Practicing without medical malpractice insurance, and is considering stopping OB. No more difficult surgeries. (Florida Medical Association affidavit)
- Dr. Stewart P. Newman — Practice: OB/GYN. No medical malpractice insurance, and is eliminating some high-risk; reducing surgery; no litigious patients. (Florida Medical Association affidavit)
- Dr. Gilbert R. Panzer — Practice: Family Practice. Restricted practice and stopped part-time employment. (Florida Medical Association affidavit)
- Dr. Theresa Rattey — Practice: Pediatric Orthopedics. Stopped doing spine surgeries in children. (Florida Medical Association affidavit)
- Dr. Jane E. Rudolph — Practice: OB/GYN. No medical malpractice insurance, and is discharging litigious patients; reducing high-risk patients. (Florida Medical Association affidavit)
- Dr. Stephen S. Scher — Practice: Gynecology. No longer performs surgery or hospital consults. (Florida Medical Association affidavit)
- Dr. Gerald Stashak — Practice: Orthopedic Surgery. Partner quit doing surgery because he couldn't justify extra $60,000 in insurance. (Florida Medical Association affidavit)
- Dr. Ross G. Stone — Practice: Orthopedic Surgery. Stopped pediatric reconstructive, spinal surgery, and reconstructive hand surgery. (Florida Medical Association affidavit)
- Dr. Jerome B. Vincente — Practice: Primary Care/Internal Medicine. Stopped ER call; refers high-risk patients to specialists who then refer to teaching hospitals. (Florida Medical Association affidavit)
- Dr. Antonio Abadia — Practice: Anesthesiology. Will no longer provide elective care to patients without a complete set of lab values "within normal limits." (Florida Medical Association affidavit)
- Dr. Kenneth Barrod — Practice: Orthopedic Surgery. Stopped high-risk procedures, and has stopped all treatment of problems with unpredictable outcomes. (Florida Medical Association affidavit)
- Dr. William Caskey — Practice: Anesthesiology. Will no longer provide elective care to patients without a complete set of lab values "within normal limits." (Florida Medical Association affidavit)

- Dr. James Cole — Practice: Anesthesiology. Will no longer provide elective care to patients without a complete set of lab values "within normal limits." (Florida Medical Association affidavit)
- Dr. Norman Grenrich — Practice: Cardiology. Declined to see certain high-risk patients in consultation, such as patients with OB complications. (Florida Medical Association affidavit)
- Dr. Kenneth Fuquay — Practice: Pulmonary. Forced to cancel medical malpractice insurance because he can't afford it. (Florida Medical Association affidavit)
- Dr. Nathan E. Nachlas — Practice: Facial Plastic Surgery. Has stopped performing all high-risk surgeries. (Florida Medical Association affidavit)
- Dr. Edward Smolar — Practice: Endocrinology Metabolism. Stopped seeing complicated cases, and has curtailed office hours by 50%. (Florida Medical Association affidavit)
- Dr. John A. Van Houten — Practice: Orthopedic Surgery. Has limited ER call, refers more cases out, and may be forced to retire in another year. (Florida Medical Association affidavit)
- Dr. Steven Varady — Practice: Urology. Is unable to care for pregnant patients, and unable to care for excessively high-risk patients. (Florida Medical Association affidavit)
- Dr. Eric Weiner — Practice: Internal Medicine. Closed practice to new HMO/PPI patients, no high-risk, and is only accepting private patients with review. (Florida Medical Association affidavit)
- Dr. Raj Khambhati — Practice: Internal/Geriatric Medicine. Has stopped seeing patients in nursing homes even though specialty is geriatric medicine. (Florida Medical Association affidavit)
- Dr. Douglas G. MacLear — Practice: Anesthesiology/Pain Management. No morphine pumps or spinal cord stimulator placements, and doesn't see patients in ER now. (Florida Medical Association affidavit)
- Dr. Timothy Allison — Practice: Emergency Medicine. All neurologists in northern Palm Beach have withdrawn from call; lost 3 neurosurgeons in the past 2 years; only hospital in multi-county region with ophthalmology; pediatricians refuse to see patients under 12 years old; general surgeons will no longer perform routine pediatric cases; lack of trauma coverage. Specialties affected: Emergency Medicine, Neurology, Neurosurgery, Ophthalmology, Pediatrics/Pediatric Surgery, Trauma Care Center. (Florida Medical Association affidavit)
- Dr. Peter Lamelas — Practice: Emergency Medicine. There is no neurosurgical coverage most of month. Neurosurgeon has dropped privileges to do any aneurysms. No neurosurgeon will operate on aneurysms (non-traumatic) in Palm Beach County as well as parts of Broward and Martin Counties. I recently personally cared for and tried to transfer one particular patient (while my ED filled up with other

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sick patients waiting to be seen) because none of the 22 hospitals with neurosurgeons that I called do aneurysms because of their "high liability." Inevitable poor outcomes. This patient died. There is also no ophthalmologist on staff, no hand surgery, and no ENT at my hospital. All the surgeons dropped ER coverage and most send their sickest patients to the ED because it limits their risk. Specialties affected: Burns, Hand Surgery, Neurosurgery, Obstetrics, Ophthalmology, Oral/Maxillo-Facial Surgery, Otolaryngology, Pediatrics/Pediatric Surgery. (Florida Medical Association affidavit)

CENTRAL FLORIDA

Bradenton County

- Dr. James Clark — Practice: OB/GYN. Stopped practicing obstetrics. (Florida Medical Association affidavit)
- Dr. Mahmoud Mostafaui — Practice: Family Practice. Stopped seeing risk patients and increased coverage. (Florida Medical Association affidavit)

Brevard County

- Physicians at Cape Canaveral Hospital temporarily suspended all elective surgeries. (*Associated Press*, May 23, 2003)
- Dr. Mark Rubenstien specializes in physical medicine and rehabilitation Cocoa Beach, and has always been on the "low end" of the medical liability premium list. As a result of this crisis, he has stopped taking referrals to do epidural steroid injections, a procedure he has been doing for ten years. It is the riskiest in his pain practice so he has stopped performing it in an effort to avoid denial of insurance coverage. (Dr. Mark Rubenstien, January 2003 academic task force report)
- Dr. Homi Cooper — Practice: Occupational/Environmental Medicine. Stopped seeing "coached" patients or patients who see their lawyers before their doctors. (Florida Medical Association affidavit)
- Dr Michael Delk — Practice: Anesthesiology. Terminated chronic pain practice and obstetrics practice. Limited regional practice. (Florida Medical Association affidavit)
- Dr. Gopal Gadodia — Practice: Cardiology. Asks patients to sign every time they postpone a procedure. Performs more procedures to CYA. (Florida Medical Association affidavit)
- Dr. Mark Galfo — Practice: Family Practice. Stopped private practice and went to work for the hospital. Orders more tests and x-rays. (Florida Medical Association affidavit)
- Dr. James Honig — Practice: OB/GYN. Stopped OB practice. (Florida Medical Association affidavit)
- Dr. Badr Ibrahim — Practice: Neurology. Stopped seeing patients with head trauma, and is now referring them to outside hospital. (Florida Medical Association affidavit)

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- Dr. Paul Isenbarger — Practice: Interventional/Diagnostic Radiology. Considering moving. Stopped performing intracranial interventions and high-risk biopsies. (Florida Medical Association affidavit)
- Dr. Richard Kirkpatrick — Practice: Dermatology. Limit types of problems and certain types of groups with increase risk of claims. (Florida Medical Association affidavit)
- Dr. Michael McLaughlin — Practice: General/Thoracic Surgery. Stopped performing pancreatic and esophagael surgeries. (Florida Medical Association affidavit)
- Holmes Regional Medical Center, Inc. — Doctors have left Brevard County. They have withdrawn from covering the Level II Trauma Service, are selectively dropping high-risk care privileges, withdrawing from ER coverage, and leaving gaps in the ER call schedule.
- Dr. Lawrence Robinson — Practice: Orthopedic Surgery. No longer performs many trauma procedures. (Florida Medical Association affidavit)
- Dr. Paul Buza — Practice: Neurology. Any further increase in premiums will result in his having to change careers or stop practicing. (Florida Medical Association affidavit)
- Dr. Jonathan Charles — Practice: Pathology. Many diagnoses are evasive. (Florida Medical Association affidavit)
- Dr. Paul Calise — Practice: Neurology. Stopped performing spinal taps, and provides little or no ER coverage. (Florida Medical Association affidavit)
- Dr. Parvesh Bansal — Practice: Critical Care Medicine. Stopped any invasive procedures. (Florida Medical Association affidavit)
- Dr. Robert Cline — Practice: Cardiac Surgery. Stopped high-risk cardiovascular procedures. (Florida Medical Association affidavit)
- Dr. Brian C. Dowdell — Practice: Physical Med & Rehab. Stopped more invasive procedures, and has limited patients who may be litigious. (Florida Medical Association affidavit)
- Dr. Rajesh Malik — Practice: Internal Medicine. Moving 7-31-03. (Florida Medical Association affidavit)
- Dr. Miguel Mateos-Morro — Practice: Infectious Diseases. Doesn't see pregnant females, or children. (Florida Medical Association affidavit)
- Dr. Lynne Miner — Practice: OB/GYN. Nurse/midwife practice has dissolved due to liability concerns. (Florida Medical Association affidavit)
- Dr. Stephanie Naoumoff — Practice: Family Practice. Liability coverage for nursing homes is too high. (Florida Medical Association affidavit)

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- Dr. Nicholas Potochny — Practice: Psychiatry. Denial of PLI secondary to on-site Assisted living patient visits, and has limited to "fee-for-service" only. (Florida Medical Association affidavit)
- Wuesthoff Health System, Inc. — Three-fold increase in malpractice/liability insurance cost over past 3 years plus 8-fold increase in deductible. Deductible increase has resulted in limiting funds to increase services. Many physicians contemplating leaving state. Difficulty recruiting due to high malpractice insurance. Over 50 physicians needed between Melbourne and Rockledge. (Florida Hospital Association affidavit)
- Dr. David E. Hallstrand, Jr. — Practice: Anesthesiology. Stopped thoracic epidurals, morbid obesity patients. (Florida Medical Association affidavit)
- Dr. Ricardo A. Henriques — Practice: Primary Care/Internal M. Will probably be leaving the state as of 2004. (Florida Medical Association affidavit)
- Dr. James D. Kearney — Practice: Internal Medicine. No longer attends any nursing homes because of liability. (Florida Medical Association affidavit)
- Dr. John C. Kennedy — Practice: Pediatrics. Stopped attending C-sections, providing care to newborns w/even minor problems. (Florida Medical Association affidavit)
- Dr. Michael F. Lane — Practice: Gen. Surgery/Vascular Surgery. Unwilling to observe a breast lesion, biopsy is legally safer. (Florida Medical Association affidavit)
- Dr. Lizzy R. Thomas — Practice: Internal Medicine. Considering quitting practice after 25 years and is only 56. (Florida Medical Association affidavit)
- Dr. Richard C. Wilson — Practice: Pediatric Medicine. Restricted treatment of pediatric cases, diabetic patients and all high-risk surgery. (Florida Medical Association affidavit)
- Dr. Peter M. Zies — Practice: Dermatology. Stopped taking PUVA patients. (Florida Medical Association affidavit)
- Dr. Samuel DelRio — Practice: OB/GYN. Stopped high-risk OB, and avoids surgery on medically complicated patients. (Florida Medical Association affidavit)
- Dr. Steven Padnus — Practice: Pulmonary Medicine. Is leaving medical practice for a different occupation. (Florida Medical Association affidavit)
- Dr. Nikhita Shah — Practice: Endocrinology. Stopped emergency room call, and stopped seeing very non-compliant patients. (Florida Medical Association affidavit)
- Dr. Milan Jockovich — Practice: Emergency Medicine. General surgery unwilling to take trauma center call; difficulty recruiting EM physicians; frequent unavailability of hand surgeons; neurology back up is unavailable so patients must be transferred; unable to start pediatric intensive care unit due to pediatricians' liability concerns;

surgeons are not handling pediatric cases; patients often cannot get specialty care when they are in need. Specialties affected: Cardiology, Emergency Medicine, General Surgery, Hand Surgery, Neurology, Oral/Maxillo-Facial Surgery, Orthopedics, Pediatrics/Pediatric Surgery, Radiology, Urology, Vascular Surgery. (Florida Medical Association affidavit)

- Dr. James Miles — Practice: Emergency Medicine. Nearly all specialists dropped privilege at Palm Bay Community Hospital; no neurologist to care for strokes, orthopedic surgeon available only 50% of the time; many surgical specialists, such as cardiothoracic surgeons and urologists have stopped treating patients under 18 years of age; 75% of the time there is no hand surgeon available in the entire county of Brevard. On at least two occasions, I have been unable to get a hand surgeon to care for hand emergencies. This was despite calling every hand surgeon in this county, and hand surgeons at major referral centers in Miami, West Palm Beach, Orlando, Tampa, Daytona Beach, Gainesville, and Jacksonville. Specialties affected: Hand Surgery, Neurology, Orthopedics, Pediatrics/Pediatric Surgery. (Florida Medical Association affidavit)

Citrus County

- Dr. Ralph Rogers — Practice: Surgery. Stopped pediatrics, high-risk, and ER. (Florida Medical Association affidavit)
- Dr. Carl Rosenbrough — Practice: Ophthalmology. Limited doing interocular surgery (cataract surgery). (Florida Medical Association affidavit)
- Dr. Allan Hedges — Practice: OB/GYN. Will stop OB as of 12-31-03. (Florida Medical Association affidavit)
- Dr. Laurence Ferber — Practice: General/Vascular. Won't accept high-risk patients. (Florida Medical Association affidavit)
- Dr. Mark Fernandez — Practice: General Surgery. Not accepting new breast patients, eliminated high-risk surgeries, and is referring patients elsewhere. (Florida Medical Association affidavit)
- Dr. Thomas Hendrick — Practice: General Surgery. Not performing esophageal or high-risk vascular surgeries. (Florida Medical Association affidavit)
- Dr. Donald Carmichael — Practice: General Surgery. Stopped doing trauma services, PEDS, complex vascular procedures. (Florida Medical Association affidavit)
- Dr. Dennis Dewey — Practice: Neurology. No longer accepts new Medicaid or patients with no health insurance. (Florida Medical Association affidavit)
- Dr. Lauren E. McDowell — Practice: General Surgery. Decreased types of laparoscopic surgery services, breast pt, vascular surgeries, no c-sections, or pediatric. (Florida Medical Association affidavit)

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DeSoto County

- Dr. Dumitru-Dan Teodorescu, an Arcadia-based OB/GYN who has been in practice since 1981, is one of two obstetricians who take care of the needs of women in DeSoto County and part of Hardee County. Dr. Teodorescu's insurance carrier informed him his policy would not be renewed. If he cannot find another carrier, he will not longer be able to practice in Florida and only one obstetrician would be left in DeSoto. (Dr. Dumitru-Dan Teodorescu, January 2003 academic task force report)

Hernando County

- Oak Hill Hospital in Brooksville eliminated its obstetrical unit and on-call neurosurgery coverage in its emergency department. (Oak Hill Hospital in FHA Survey, January 2003)
- Dr. Adel Eldin — Practice: Cardiology. Stopped performing high-risk procedures. (Florida Medical Association affidavit)
- Dr. Elliott Hinkes — Practice: Orthopedic Surgery. Stopped performing high-risk cases, and has limited ER care. (Florida Medical Association affidavit)
- Dr. Joseph Idicula — Practice: Cardiology. Cut down patients; thinking of going bare as of Dec. 2003. (Florida Medical Association affidavit)

Hillsborough County

- Three surgical physicians and three primary care physicians associated with South Bay Hospital had cut routine services. (*Tampa Tribune*, May 28, 2003)
- Two gynecologists were closing their practice near St. Joseph's Women's Hospital, leaving their caseload of about 7,000 women to find care elsewhere. (*St. Petersburg Times*, May 15, 2003)
- Brandon Regional Hospital has had several impacts: General surgery - one surgeon retired early because he did not want to pay the increased premium and one relocated to Virginia. Orthopedics - one orthopedic surgeon retired early because he did not want to pay the increased premium and one is relocating to North Carolina effective 7/31/03. Urology - one surgeon was unable to obtain malpractice coverage and was ultimately able to obtain coverage through another hospital system. He subsequently resigned from the medical staff. Plastic surgery - two physicians resigned because the hospital was not willing to pay them rates for ER coverage at levels they wanted which they insisted was due to the premium increase on their malpractice insurance and the cost for covering the ER increases the premium. The hospital has only one remaining plastic surgeon. Pediatric surgery – the hospital's one pediatric surgeon has reduced his privileges to courtesy because of his responsibilities to cover another area hospital's ER. (Brandon Regional Hospital, July 2003, FHA Survey)
- Dr. Gaspar R. Salvadore, a family physician in Sun City Center since 1979, had his insurance policy non-renewed and was turned down for coverage by seven insurers before winding up in the state-run JUA. (Dr. Gaspar R. Salvadore, January 2003 academic task force report)
- Dr. Larry Fishman, a neurosurgeon in Hillsborough County for 14 years, said there are many procedures he does not feel comfortable performing anymore, such as aneurysm surgery, surgery on many brain tumor, and most pediatric neurosurgery.

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For the past six months, he has basically stopped providing care to Medicaid patients because the potential risks and liability are just too great. (Dr. Larry Fishman, January 2003 academic task force)

- Dr. Michael Binder, a Tampa urologist, saw his insurance premiums increase 115 percent in two years, in spite of the fact he has never been sued in 15 years of practice. To help keep rates down, he has given up performing any radical surgeries and no longer performs cosmetic surgeries. (Dr. Michael Binder, January 2003 academic task force report)
- Dr. Thomas Peurifoy is a general vascular surgeon who practiced in Sun City Center and Manatee County for nearly two decades. He moved to another state when his insurance carrier left Florida and his premiums went up 300 percent. (Dr. Thomas Peurifoy, January 2003 academic task force report)
- Dr. John Dunne is a thoracic and vascular surgeon who has practiced in Sun City Center for 20 years. When his premiums went up to more than $120,000, he limited his practice to cosmetic vein surgery in his office. (Dr. John Dunne, January 2003 academic task force report)
- Dr. Richard Landigran is a urologist who resigned from South Bay Hospital's emergency staff in October 2002 because of his inability to obtain insurance. He is no longer practicing in a hospital setting. (Dr. Richard Landigran, January 2003 academic task force report)
- Dr. Scott A. Rodger, a family practitioner in Eustis, said his malpractice insurer left the state, forcing him to buy two policies resulting in an increase of over 400 percent in his insurance costs. He is considering retiring or moving elsewhere. (Dr. Scott A. Rodger, January 2003 academic task force report)
- Dr. Alexis Rojas, an OB/GYN in Leesburg, said her insurer left the state and she is having trouble finding coverage. (Dr. Alexis Rojas, January 2003 academic task force report)
- Tampa Bay area pediatric neurosurgeon Dr. Gerald Tuite has stopped seeing patients who may require high-risk procedures and has been considering positions in other states where the liability risk is less. (Dr. Gerald Tuite, January 2003 academic task force report)
- Luke Wiegand, medical student at University of South Florida College of Medicine, states he is not planning to practice in Florida due to the medical liability climate in Florida. (E-mail message from Luke Wiegand to the FMA, July 21, 2003)
- Dr. Cecil Aird — Practice: Hand Surgery. Reduced number of surgeries performed due to risk of non-union. (Florida Medical Association affidavit)
- Dr. John Baker — Practice: Orthopedic Surgery. Stopped performing spine surgeries. (Florida Medical Association affidavit)
- Dr. Donald Behnke — Practice: Internal Medicine. No longer sees high-risk patients. Partner of 20 years has quit. (Florida Medical Association affidavit)

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- Dr. Michael Binder — Practice: Urology. Doesn't perform high-risk procedures, has eliminated most HMO's, and has stopped accepting Medicaid patients. (Florida Medical Association affidavit)
- Dr. Madelyn Butler — Practice: OB/GYN. High-risk OB patients are being referred elsewhere. (Florida Medical Association affidavit)
- Dr. Alden Cockburn — Practice: Urology. Currently interviewing for out-of-state position. (Florida Medical Association affidavit)
- Dr. Joseph Krebs — Practice: Geriatrics. Quit private practice and joined Veterans hospital as government employee. (Florida Medical Association affidavit)
- Dr. Carlos Lamontte — Practice: OB/GYN. Stopped accepting late prenatal care OB patients, and stopped providing high-risk OB care. (Florida Medical Association affidavit)
- Dr. Chumphol Mahapaurya — Practice: OB/GYN. Stopped performing high-risk procedures. (Florida Medical Association affidavit)
- Dr. Querubin Mendoza — Practice: Cardiology. Stopped seeing pregnant patients with heart disease. (Florida Medical Association affidavit)
- Dr. Mark Overman — Practice: Internal medicine. Stopped treating residents in the local nursing facility. (Florida Medical Association affidavit)
- Dr. Fabio Fiore — Practice: Orthopedics. Stopped seeing certain types of cases; stopped performing high-risk procedures. (Florida Medical Association affidavit)
- Dr. Larry Fishman — Practice: Neurosurgery. No longer treats aneurysms, trauma, or Medicaid patients. Nothing that is not "bread and butter." (Florida Medical Association affidavit)
- Dr. Armando Gutierrez — Practice: OB/GYN. Limited obstetrics, and have stopped performing certain procedures. (Florida Medical Association affidavit)
- Dr. Gary Hedrick — Practice: Dermatology. Stopped seeing children and pregnant women. No longer performs laser resurfacing procedures. (Florida Medical Association affidavit)
- Dr. Peter Jacobson — Practice: Internal Medicine. Cancelled malpractice insurance and resigned from all hospital staffs. (Florida Medical Association affidavit)
- Dr. Ravindra Patel — Practice: General/Vascular Surgery. Malpractice premiums have gone up since 1999. (Florida Medical Association affidavit)
- Dr. Ana Verdeja — Practice: OB/GYN. Has stopped accepting late prenatal care. Terminated patients if they do not keep more than 2-3 appointments. Stopped accepting self-pay OBs. Stopped doing high-risk OB care. Stopped operating on high-risk GYN patients. (Florida Medical Association affidavit)

- Dr. Barry Verkauf — Practice: GYN. Orders more tests than would otherwise due to the need to practice defensive medicine. If climate does not change then will curtail surgical practice, retire earlier than planned or change line of work to administrative medicine. (Florida Medical Association affidavit)
- Dr. Sajeen Veitichira — Practice: Pulmonary/Critical Care. Very difficult to get insurance. Cost has gone up significantly. (Florida Medical Association affidavit)
- Dr. Hector Vila — Practice: Anesthesiology. Moved to Florida 2 years ago from South Carolina and has limited practice to being a state employee where he has sovereign immunity. Has not entered private practice because of liability cost and risk. (Florida Medical Association affidavit)
- Dr. Jorge Villalba — Practice: Child Psychiatry. Stopped providing services to developmentally delayed adults and children in state-sponsored group homes. Closed private practice. (Florida Medical Association affidavit)
- Dr. Daniel Vincent — Practice: Otolaryngology. Family practiced medicine in Florida for 11 generations and yet he must now consider moving to another state for economic reasons. Between rising malpractice costs and diminishing reimbursements, medical practice in Florida is extremely difficult. Colleagues in other southern states pay half as much for malpractice coverage. (Florida Medical Association affidavit)
- Dr. Edgar Sapp — Practice: Family Practice. Decreased office surgery, x-ray in office. Refers more complicated problems out. (Florida Medical Association affidavit)
- Dr. Bruce Shephard — Practice: OB/GYN. Has been delivering babies for 25 years. Has stopped accepting pregnant patients with insulin-dependent diabetes, severe high blood pressure or sickle cell disease. (Florida Medical Association affidavit)
- Dr. Alan Itzkowitz — Practice: Emergency Medicine. Unable to obtain specialists to see patients in the ER, and must practice defensive medicine. (Florida Medical Association affidavit)
- Dr. Mutaz Habal — Practice: Plastic Surgery/Trauma. Accepts no more risky adults/high-risk patients. (Florida Medical Association affidavit)
- Dr. Norman Edgerton, Jr. — Practice: Gastroenterology. Stopped performing liver biopsies, paracentesis, and refers high-risk patients to university. (Florida Medical Association affidavit)
- Dr. Antonio Prado — Practice: Ophthalmology. Stopped affiliation with all hospitals but one. Some hospitals don't have ophth. coverage. (Florida Medical Association affidavit)
- Dr. William Davison — Practice: Emergency Medicine. Physicians do not want to take liability for emergency patients, whether insured or not. Trauma center not taking patients readily because they are overwhelmed. Specialties affected: Burns, General Surgery, Hand Surgery, Ophthalmology, Oral/Maxillo-Facial Surgery,

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Orthopedics, Otolaryngology, Pediatrics/Pediatric Surgery, Plastic Surgery, Psychiatry, Trauma Care Center. (Florida Medical Association affidavit)

Indian River County

- Dr. Charles Fischman — Practice: Pulmonary/Allergy. Stopped performing critical care, high-risk, and invasive procedures. (Florida Medical Association affidavit)
- Dr. Jeffrey Livingston — Practice: Otolaryngology. No longer performs high-risk surgeries, and will not repair facial or joint fractures. (Florida Medical Association affidavit)
- Dr. Ralph Rosato — Practice: Plastic Surgery. No longer works with physicians who have dropped their insurance; limited ER call. (Florida Medical Association affidavit)
- Dr. Seth Coren — Practice: Orthopedic Surgery. Stopped performing high-risk surgeries. (Florida Medical Association affidavit)
- Dr. Samuel Jacobson — Practice: Pulmonary/ Critical Care. Declining to see pregnant or pediatric patients. (Florida Medical Association affidavit)
- Dr. Roger Meyer — Practice: Ophthalmology-Retina. Dropped hospital privileges; stopped doing retinal detachment surgery (high liability). (Florida Medical Association affidavit)
- Dr. Derek K. Paul — Practice: General Surgery. Decreased ER cases & calls; high-risk elective surgery sent elsewhere. (Florida Medical Association affidavit)
- Dr. Curtis Dalili — Practice: Internal Medicine. Will not see high-risk or non-compliant patients; they threaten his livelihood. (Florida Medical Association affidavit)
- Dr. John Davidson — Practice: Orthopedic Surgery. Reduced ER call coverage re: trauma, and refuses certain types of surgical cases. (Florida Medical Association affidavit)
- Dr. Heidi Gorsuch — Practice: General Surgery. Stopped ER call, and is actively investigating moving to another state and closing her practice. (Florida Medical Association affidavit)
- Dr. Michael P. Tonner — Practice: Pulmonary Medicine. No longer sees worker's compensation patients, and has reduced malpractice coverage. (Florida Medical Association affidavit)
- Dr. Gregory D. MacKay — Practice: Gastroenterology. Trained to do new procedures to treat acid reflux, but cannot perform them in this malpractice climate. (Florida Medical Association affidavit)
- Dr. Dawn Davidson-Jockovich Practice: Emergency Medicine. No obstetric care in hospital. Women in active labor must be delivered in the ER by an ER physician, without fetal monitoring or the ability to do emergent C-sections. In small ED, patient care is frequently made more difficult by lack of specialists in OB-GYN,

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neurosurgery, vascular surgery, trauma and pediatrics. If a patient requires immediate care by a specialist, valuable time is lost trying to find an available specialist at another hospital. This has become a more difficult problem over the last two years. Specialties affected: Burns, Emergency Medicine, Gynecology, Hand Surgery, Neurosurgery, Obstetrics, Ophthalmology, Oral/Maxillo-Facial Surgery, Otolaryngology, Pediatrics/Pediatric Surgery, Plastic Surgery, Trauma Care Center, Thoracic Surgery. (Florida Medical Association affidavit)

Lake County

- Dr. Stephen Asmann — Practice: Family Practice. Group lost a partner and business has closed. Now trying to sell a satellite office. (Florida Medical Association affidavit)
- Dr. Maryssa Aziz-Toppino — Practice: Ophthalmology. Restricted cataract surgery to low-risk patients, and has reduced number of lasik and refractive surgeries performed. (Florida Medical Association affidavit)
- Dr. Charles Cartwright — Practice: Urology. No longer sees pediatric patients or high-risk adults. (Florida Medical Association affidavit)
- Dr. Keith Charles — Practice: Ophthalmology. Stopped high-risk surgeries, ER calls, and pro-bono trauma cases. (Florida Medical Association affidavit)
- Specialty coverage for emergency and/or trauma care has compromised the provision of emergency/trauma care in the following specialty areas: Emergency Medicine, Hand Surgery, Obstetrics. (Florida College of Emergency Physicians affidavit)
- This reporting emergency physician is the managing partner for an emergency physician group that cares for more than 200,000 patients per year in 7 EDs throughout Central Florida (Orange, Seminole, Osceola, Lake, and Marion counties). The hospitals include: Orlando Regional Medical Center (Level I Trauma Center), Sand Lake Hospital, South Seminole Hospital, St. Cloud Hospital, South Lake Hospital, The Villages Regional Hospital. This reporting emergency physician states that access to care is being threatened in our emergency departments, our healthcare safety net, for multiple reasons. Medical malpractice reform is crucial to remove one of the disincentives that currently exist for physicians to provide care to emergency patients. The reporting emergency physician indicates that patients' access to specialists has been affected in all of our EDs in the Orlando Regional Healthcare System. (Florida College of Emergency Physicians affidavit)
- Reporting emergency physician indicates that governmental and private payors have been reducing reimbursement while are patients are ever more ill and emergency department services are ever more complex. The affected emergency physician group has seen medical liability insurance options dwindle, and have experienced 100% and 140% increases in liability insurance costs in the past two years. To face personal financial ruin with the specter of a multimillion-dollar claim for services provided under governmental mandate (i.e. EMTALA) and often without compensation does not seem to be a sustainable proposition unless action is taken. Important to the stability of emergency services is the recognition of the special role that EDs play in the care of the must acutely ill and underserved. (Florida College of Emergency Physicians affidavit)

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- Reporting emergency physician indicates that neurosurgery coverage at Leesburg Regional Medical Center, the largest hospital is Lake County, is hampered by the fact that there is only one neurosurgeon on staff, and he is not available to take call all of the time. (Florida College of Emergency Physicians affidavit)
- Dr. Christopher Gazik — Practice: Family Medicine. No longer accepts patients with certain medical conditions, and refers patients to specialists. (Florida Medical Association affidavit)
- Dr. Stacia Goleley — Practice: Ophthalmology. Relinquished privileges at hospital to lower liability. (Florida Medical Association affidavit)
- Dr. James Hardy — Practice: ENT. Stopped hospital and outpatient surgery, and limits practice to office procedures. (Florida Medical Association affidavit)
- Dr. Peter Marzek — Practice: Plastic Surgery. Dropping ER call at one or maybe two of his hospitals. (Florida Medical Association affidavit)
- Dr. Scott Wehrly — Practice: Ophthalmology. Will not perform any high-risk procedures. (Florida Medical Association affidavit)
- Dr. John Berckes — Practice: Anesthesiology. Stopped accepting general anesthesia cases. (Florida Medical Association affidavit)
- Dr. Richard Bosshardt — Practice: Plastic Surgery. Is considering dropping hospital privileges and/or ER call at several hospitals. (Florida Medical Association affidavit)
- Dr. Norman Levy — Practice: Ophthalmology. Stopped cosmetic and lasik surgeries, vitrectomy, and treatment of retinopathy. (Florida Medical Association affidavit)
- Dr. Lisa Lorelli — Practice: Family Practice. Refers prenatal care, surgical, and office derm. procedures, and limits pediatrics. (Florida Medical Association affidavit)
- Dr. Sharon Nickel-Olm — Practice: Family Medicine. Stopped hospital practice, and can no longer afford malpractice premiums. (Florida Medical Association affidavit)
- Dr. R.O. Holton, Jr. — Practice: Radiology. Thirty plus years experience; no more mammography; no more malpractice insurance. (Florida Medical Association affidavit)
- Dr. Wendy Perrott — Practice: OB/GYN. No high-risk pregnancy, reduced surgeries, no genetic amnios, and no new patients. (Florida Medical Association affidavit)
- Dr. Gerald E. Reynolds — Practice: Family Practice. Reduced nursing homes by 90%, no new patients in nursing homes. (Florida Medical Association affidavit)
- Dr. Maria Cristina Soto — Practice: Pediatrics. Will not accept high-risk patients. (Florida Medical Association affidavit)

- Dr. Tully C. Patrowicz — Practice: Ophthalmology. Is in semi-retirement, lowest risk category. Limited to office-based part-time practice. (Florida Medical Association affidavit)
- Dr. Steven E. Pillow — Practice: OB/GYN. Limits emergency department, number of prenatal patients, refers high-risk patients, all consultants 45-plus miles. (Florida Medical Association affidavit)
- Dr. Ronald G. Rynn — Practice: Family Practice. Does not do nursing home procedures or visits even for those I followed previously. (Florida Medical Association affidavit)

Manatee County

- Two physicians from Manatee Surgical Associates stopped seeing patients at Manatee Memorial Hospital, while two others took an indefinite leave of absence. (*Bradenton Herald*, May 28, 2003)
- Three physicians from Bradenton Surgical Associates stopped seeing patients at Manatee Memorial Hospital. (*Bradenton Herald*, May 28, 2003)
- Dr. Celestino Palomino and four other Bradenton kidney specialists, including Dr. Thomas Braxton, chief of staff at Manatee Memorial Hospital, recently had no choice but to close their doors until they found new coverage after their insurance carrier left the state. In the interim there was only one kidney specialist to cover more than 400 patients on dialysis. The process took weeks until a temporary fix could be found. Dr. Palomino has said an entire specialty being forced to shut down in his community is likely to happen again, unless a fix is found. (*Bradenton Herald*, June 15, 2003)
- 34 specialists and surgeons closed their offices until legislative relief is granted, including Gulf Coast Urology. (*Sarasota Herald Tribune*, May 23)
- Ten cardiologists from the Bradenton Cardiology Center closed their offices to all but emergency cases. (*Bradenton Herald*, May 28, 2003)
- After recently moving from Birmingham, Alabama to Bradenton, orthopedic surgeon Dr. James Floyd has made plans to move back to by 2004 due to the cost of medical liability insurance. (Dr. James Floyd, January 2003 academic task force report)
- Dr. Eric Gestrich and Internal Medicine physician in Bradenton is closing his office this summer due to a non-renewal of his insurance this summer. (Manatee County Medical Society, July 1, 2003).
- Dr. Jesse Peurifoy, general surgeon and Dr. Eric Gestrich, internal medicine have left Manatee County. Dr. George Gallati, general surgeon and Dr. Allen Sklerov, urologist have retired early. Dr. John Dunne, limited practice to only a select vascular procedures; Dr. Denise Baker stopped delivering babies only doing Gyn now; Dr. Tom Thomas stopped delivering babies only doing Gyn; Dr. Daniely Celaya and Dr. Celestino Palomino only doing nephrology now. (Manatee County Medical Society, July 3, 2003)

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- Dr. Jorge Alvarez — Practice: OB/GYN. Stopped seeing majority of high-risk obstetric patients. (Florida Medical Association affidavit)
- Dr. Vinai Artyamsoal — Practice: OB/GYN. Stopped all high-risk pregnancies and surgeries. (Florida Medical Association affidavit)
- Dr. Denise Baker — Practice: OB/GYN. Halted all obstetrics and high-risk surgeries. Listed office for sale. (Florida Medical Association affidavit)
- Dr. Clayton Ball — Practice: Anesthesiology. No longer works nights or weekends to avoid having to perform emergency surgeries. (Florida Medical Association affidavit)
- Dr. Linda Brown — Practice: OB/GYN. No longer performing high-risk surgeries or taking care of high-risk obstetric patients. (Florida Medical Association affidavit)
- Dr. Loren Carlson — Practice: Family Practice. If rates go up again, will have to drop insurance or move out of the state. (Florida Medical Association affidavit)
- Dr. Thomas DeGroat — Practice: Cardiology. Does not see pregnant women. (Florida Medical Association affidavit)
- Dr. Thomas Dunne — Practice: General Surgery. Limited practice to vein treatments, and cannot treat high-risk patients. (Florida Medical Association affidavit)
- Dr. Mahmoud Mostafaui — Practice: Family Practice. Stopped seeing high-risk patients and increased coverage. (Florida Medical Association affidavit)
- Dr. Robert Fasoli — Practice: Pulmonary Dis./Crit. Care. No longer treats ICU patients, and doesn't take ER calls. Has withdrawn from Medicaid. (Florida Medical Association affidavit)
- Dr. George Gallati — Practice: General Surgery. Moved on July 1, 2002. (Florida Medical Association affidavit)
- Dr. James Ganey — Practice: General/Thoracic/Vascular. Resigned from community hospital/ER calls; stopped certain high-risk procedures. (Florida Medical Association affidavit)
- Dr. Thomas Ganey — Practice: Internal Medicine/Geriatrics. Stopped seeing ER patients, and performing high-risk procedures. Is considering moving out of state. (Florida Medical Association affidavit)
- Dr. Irving Hall — Practice: Pediatrics. Curtailed surgical procedures. (Florida Medical Association affidavit)
- Dr. Terrence Hopkins — Practice: Dermatology. No longer performs chemical peels. (Florida Medical Association affidavit)
- Dr. Jack Jawit — Practice: Dermatology. Curtailed visits to nursing homes. (Florida Medical Association affidavit)

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- Dr. Michael LeMay — Practice: OB/GYN. Stopped practicing high-risk obstetrics, and no longer see Medicare patients. Malpractice has doubled. (Florida Medical Association affidavit)
- Dr. Karen Liebert — Practice: OB/GYN. Trying to limit high-risk OB patients, and considering stopping OB altogether. (Florida Medical Association affidavit)
- Dr. Asdollah Livani — Practice: Family Practice. Limited in office procedures, and refers patients to specialists. (Florida Medical Association affidavit)
- Dr. George Martin — Practice: Neurosurgery. Stopped performing elective aneurysm procedures among others. (Florida Medical Association affidavit)
- Dr. Jose Matta — Practice: OB/GYN. Stopped seeing high-risk OB patients. (Florida Medical Association affidavit)
- Dr. George McSwain — Practice: General Surgery. Stopped performing high-risk procedures, and dropped off ER coverage. (Florida Medical Association affidavit)
- Dr. Vincent Milazzo — Practice: General/Vascular Surgery. Stopped performing high-risk procedures, and resigned from staff at community hospital. (Florida Medical Association affidavit)
- Dr. Carlos Montero — Practice: Gastroenterology. Stopped performing liver biopsies. (Florida Medical Association affidavit)
- Dr. Janine Mylett — Practice: Internal Medicine. Stopped seeing patients in the ER, and no longer provide ER services. (Florida Medical Association affidavit)
- Dr. Robert Hillstrom — Practice: Surgery. Limited ER care. (Florida Medical Association affidavit)
- Dr. Marion Pandiscio — Practice: OB/GYN. No longer operates on high-risk patients, and doesn't care for complicated obstetrics. (Florida Medical Association affidavit)
- Dr. Charles Polis — Practice: Urology. Won't see new patients with high-risk problems, no longer performs high-risk procedures. (Florida Medical Association affidavit)
- Dr. John Roddenberry — Practice: Gastroenterology. No longer performs liver biopsies, and no longer sees Medicaid patients. (Florida Medical Association affidavit)
- Dr. Elsy Rucker — Practice: Family Medicine. Reduced coverage due to high premiums, and will not see any difficult cases. (Florida Medical Association affidavit)
- Dr. Thomas Thomas — Practice: OB/GYN. Stopped delivering babies. (Florida Medical Association affidavit)
- Dr. Craig Trigeuiro — Practice: General Practice. Does not respond to cardiac arrests or other "code" situations in the hospital. Tries to avoid being the admitting

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doctor on patients. Lost the ability to refer patients to one of the best surgeons. (Florida Medical Association affidavit)

- Dr. Robert Subbiondo — Practice: Cardiovascular Surgery. Had to reduce malpractice coverage due to unaffordable rise last 3 years and has caused stress on himself, his staff and his family. Personally knows of several physicians in the community who have left the state or retired prematurely. (Florida Medical Association affidavit)
- Dr. Martin B. Ainbinder — Practice: Diagnostic Radiology. Reduced mammography, and stopped invasive procedures-ultrasound, biopsy, cyst aspiration. (Florida Medical Association affidavit)
- Dr. Kevin L. Boyer — Practice: Neurosurgery. Avoids high-risk patient surgeries, and anticipates moving if no changes are made. (Florida Medical Association affidavit)
- Dr. David A. Bulley — Practice: Diagnostic Radiology. Reduced number of mammograms, no more interventional spine/pain management, and might quit. (Florida Medical Association affidavit)
- Dr. Allen Meske — Practice: Emergency Medicine. Must practice defensive medicine. (Florida Medical Association affidavit)
- Dr. John Milazzo — Practice: Gen./Vascular/Thoracic. Eliminated some high-risk procedures, and resigned from 1 hospital to cut back ER call. (Florida Medical Association affidavit)
- Dr. Michael Edwards — Practice: Radiology. Mammography—decreased numbers due to liability and low reimbursement. (Florida Medical Association affidavit)
- Dr. Steven P. Lipman — Practice: Radiology. Practice has reduced mammography services by 50%. (Florida Medical Association affidavit)
- Dr. David Nonell — Practice: Emergency Medicine. The liability crisis has severely limited the coverage of specialists in our ER. Recruiting emergency physicians has been very difficult secondary to the cost of insurance. Specialties affected: Burns, Cardiovascular Surgery, Emergency Medicine, General Surgery, Gynecology, Hand Surgery, Neurosurgery, Obstetrics, Oral/Maxillo-Facial Surgery, Orthopedics, Otolaryngology, Plastic Surgery, Radiology, Thoracic Surgery, Vascular Surgery. (Florida Medical Association affidavit)
- Dr. Ramon Pabalan — Practice: Emergency Medicine. More than half of the general surgeons have resigned from staff, primarily to avoid ER call. Specialties affected: Burns, Cardiology, Cardiovascular Surgery, Emergency Medicine, General Surgery, Gynecology, Hand Surgery, Neurosurgery, Obstetrics, Oral/Maxillo-Facial Surgery, Orthopedics, Pediatrics/Pediatric Surgery, Plastic Surgery, Psychiatry, Radiology, Thoracic Surgery. (Florida Medical Association affidavit)

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Marion County

- Dr. Mark Mishkind, general surgery, moved to California at end of June 2003 (story also reported in the Ocala Star Banner, June 18, 2003); Dr. James Giliberto, general surgery, moved to New England area end of 2002; Dr. Hiba Muhtasib, OB/Gyn, moving out of the country in July 2003; Dr. Carolyn Cain, pediatrics, stopped practicing due to cost of insurance; Dr. Joseph Webster, OB/Gyn, retired due to cost of insurance. (Marion County Medical Society, July 7, 2003).
- Dr. Mary Baum —Practice: Gynecology. No longer practices obstetrics. (Florida Medical Association affidavit)
- Dr. Phillip Bruner — Practice: OB/GYN. Stopped seeing high-risk obstetrics patients and performs limited gynecological procedures. (Florida Medical Association affidavit)
- Dr. David Cunningham —Practice: Urology. Limits high-risk procedures. (Florida Medical Association affidavit)
- Dr. Manuel Delcharco — Practice: OB/GYN. No longer performs high-risk obstetrics and gynecological surgeries. Transfers patients to Shands Hospital. (Florida Medical Association affidavit)
- Dr. Michael Freeman — Practice: Dermatology. Stopped seeing laser patients due to the high insurance. (Florida Medical Association affidavit)
- Dr. Donald Hagan — Practice: General Surgery/Family . Forced to retire early. Cannot afford the insurance premium. (Florida Medical Association affidavit)
- Dr. Leslie Hagan — Practice: Family Practice. Stopped practicing all medicine on private patients, and has dropped all charity work. (Florida Medical Association affidavit)
- Dr. Joseph Hildner — Practice: Family Practice. Has become far more exclusive with accepting new patients and screening their old patients. (Florida Medical Association affidavit)
- Dr. Juan Lora — Practice: Neurosurgery. Will have to perform 90 back surgeries a year just to pay for insurance. (Florida Medical Association affidavit)
- Dr. Raymond Marquette — Practice: OB/GYN. Refuses any high-risk and questionable OB patients. (Florida Medical Association affidavit)
- Dr. Douglas Murphy — Practice: Gynecology. Stopped OB practice. (Florida Medical Association affidavit)
- Dr. Chi-Kin Ng — Practice: Neurology. Stopped seeing high-risk medical patients. (Florida Medical Association affidavit)
- Dr. Segismundo Pares — Practice: Family/Geriatric. Is stopping nursing home care from 4 homes to 1 home, and may stop accepting Medicare. (Florida Medical Association affidavit)

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- Dr. Rakesh Prashad — Practice: Interventional Cardiology. No pregnant patients, no free care, no high-risk patients. (Florida Medical Association affidavit)
- Dr. Paul Urban — Practice: Cardiac Cath/Angio. No pregnant patients, transfers high-risk, self-pay patients to Shands. Less "charity" care, orders more tests, likely unnecessary to cover my posterior. (Florida Medical Association affidavit)
- Dr. Lance Trigg — Practice: Radiology. Decreased the number and scope of interventional radiology procedures and is considering dropping mammography altogether. (Florida Medical Association affidavit)
- Dr. Edward Sobol — Practice: OB/GYN. Stopped obstetrics, surgery. Will probably have to stop office practice. (Florida Medical Association affidavit)
- Dr. R. Asokan — Practice: Plastic Surgery. Is planning to retire early. (Florida Medical Association affidavit)
- Dr. O.F. Cannon Jr. — Practice: Orthopedic Surgery. Limiting surgery to very low-risk. (Florida Medical Association affidavit)
- Dr. Wayne Moccia — Practice: Diagnostic Radiology. Stopped performing high-risk interventional procedures. (Florida Medical Association affidavit)
- Dr. Antonio Disclafani — Practice: Neurosurgery. Restricted to non high-risk, non-complex spine surgeries, and has stopped performing brain surgery. (Florida Medical Association affidavit)
- Dr. Wagdi Faris — Practice: Orthopedic Surgery. Stopped taking ER calls, and refuses to see any type of complications from other facilities. (Florida Medical Association affidavit)
- Dr. Jose Gaupier — Practice: Neurology. Stopped seeing children (only neurologist with pediatric neurology expertise in county). (Florida Medical Association affidavit)
- Dr. Seaborn M. Hunt, III — Practice: Ophthalmology. No emergency call from 2 hospitals; ocular trauma patients must now be transferred 40 miles. (Florida Medical Association affidavit)
- Dr. Krishna Rao — Practice: Pulmonary Critical Care. No claim, yet premiums went up from $5,000 in 1999 to $29,000 in 2003. (Florida Medical Association affidavit)
- Dr. Christopher A. Rao — Practice: Family Practice. No more Medicare; medical malpractice carrier left 11/02; no one writing new policies; may move. (Florida Medical Association affidavit)
- Dr. Arthur Osberg — Practice: Emergency Medicine. At this hospital there is no GYN, ophthalmology, or neurosurgery. On-call neurology is limited. Two neurologists take consults only. Two general surgeons have left town due to malpractice concerns. Specialties affected: Emergency Medicine, General Surgery, Hand Surgery, Neurology, Ophthalmology. (Florida Medical Association affidavit)

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Martin County

- Dr. Daniel Dennison — Practice: Oncology. No longer seeing indigent patients, and is now ordering more tests. (Florida Medical Association affidavit)
- Dr. Scott Gasiorek — Practice: Radiation Oncology. Cannot afford the risks involved, so patients are referred to other centers. (Florida Medical Association affidavit)
- Specialty coverage for emergency and/or trauma care has compromised the provision of emergency/trauma care in the following specialty areas: Cardiovascular Surgery, Gastroenterology, General Surgery, Gynecology, Neurology, Neurosurgery, Orthopedics, Pediatrics/Pediatric Surgery, Plastic Surgery, Thoracic Surgery, Vascular Surgery. (Florida College of Emergency Physicians affidavit)
- Reporting emergency physician indicates that physicians do not want to perform any procedures or surgery that is risky, but needed. The physicians are competent and trained to perform such measures, but patients are sent to distant facilities, thereby delaying care and increasing expense. (Florida College of Emergency Physicians affidavit)
- Dr. Gary Griffis — Practice: Radiation Oncology. High-risk patients are referred to University Center for treatment. (Florida Medical Association affidavit)
- Dr. Sunil Gandhi — Practice: General/Thoracic. No longer operates on certain high-risk patients, and has decreased number of cases at hospital. (Florida Medical Association affidavit)
- Dr. Scott Trapper — Practice: Surgery. No longer carries malpractice insurance. Does not treat high-risk or emergency patients. "A terrible waste of my talent and education-am board certified in general surgery and vascular surgery." (Florida Medical Association affidavit)
- Dr. Robert Cooper — Practice: Plastic Surgery. Will not operate on high-risk patients. (Florida Medical Association affidavit)
- Dr. James McConnell — Practice: Otolaryngology. Stopped doing high-risk procedures. (Florida Medical Association affidavit)
- Dr. Emanuel Newmark — Practice: Ophthalmology. Stopped doing high-risk procedures. (Florida Medical Association affidavit)
- Dr. John Berry — Practice: Cardiology. Is avoiding high-risk coronary/valve cases and is turning away patients who seem unreliable for follow-up. (Florida Medical Association affidavit)
- Dr. Bill Davenport — Practice: Ophthalmology. Stopped performing high-risk procedures such as lasik. (Florida Medical Association affidavit)
- Dr. Carlos Maldonado — Practice: Surgery. Has left private practice for a hospital position that covers liability insurance. (Florida Medical Association affidavit)

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Ocala County

- Dr. Joseph Locker — Practice: Orthopedics. Limits the scope of surgeries to "low-risk." (Florida Medical Association affidavit)

Orange County

- Level One trauma center at Orlando Regional Hospital is working month to month to cover physician on call schedule. (Orlando Regional Medical Center, July 2003 FHA survey)
- Orlando Regional Sand Lake Hospital eliminated both its on-call orthopedics and urology coverage in its emergency department. (Orlando Regional Sand Lake Hospital, January 2003 FHA survey)
- The last general surgery team doing emergency surgeries at Winter Park Memorial Hospital stopped working in the hospital's emergency room. (*Orlando Sentinel*, April 7, 2003)
- Winter Park Urology Associates, the only medical group performing kidney transplants in the Orlando area, has stopped practicing as of July 1. (WFTV-TV, June 30, 2003)
- At Orlando Regional the number of radiologists willing to examine mammograms has dropped by half during the past 18 months. (*Orlando Sentinel*, July 7, 2003)
- Dr. Wei-Shen Chin, a radiologist in Orlando, said that the crisis is putting him in a difficult position: "... either I stop reading the approximately 4,000 mammograms that walk through my clinic each year or I leave the state in order to protect my family." (Dr. Wei-Shen Chin, January 2003 academic task force report)
- Dr. George H. Pope, a plastic surgeon in Winter Park has been in private practice for 15 years and is a member of Central Florida's largest plastic surgery group. The group's insurance carrier is leaving Florida. Dr. Pope hopes he will not have to return to Louisiana, where he was raised and trained. (Dr. George H. Pope, January 2003 academic task force report)
- Dr. Sebastian J. Ciancio, a urologist in Orlando, said his group of three urologists has cut back on the number and types of patients they will operate on because of liability concerns. They are unable to afford to see Medicaid patients anymore, and the group's most senior member is considering retiring because of the crisis. (Dr. Sebastian J. Ciancio, January 2003 academic task force report)
- Dr. Peter Pernicone, pathologist from Orlando, came to Florida 10 years ago but came very close to accepting a job in Idaho in an effort to escape the stressful litigation climate in Florida. (Dr. Peter Pernicone, January 2003 academic task force report)
- Dr. Michael Kahky, a general surgeon and surgical oncologist in Orlando, has been referring patients with complex problems to either Gainesville or Tampa. He would have cared for these patients locally a year ago, but now the risk is too great. (Dr. Michael Kahky, January 2003 academic task force report)

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- Dr. Matthew R. Mervis, an administrative partner for a 10-physician OB/GYN practice in Winter Park, said that in the past six months multiple obstetricians ceased practicing in metro Orlando. As a result, his practice has seen wait times for gynecological appointments balloon from four to six months. (Dr. Matthew R. Mervis, January 2003 academic task force report)
- Winter Park obstetrician, Dr. John D. Guarneri, has said he will be forced to give up his obstetrics practice if the Legislature fails to act. (Dr. John D. Guarneri, January 2003 academic task force report)
- Dr. Ivan Castro, a general internist in Winter Park, can no longer see patients in nursing homes due to stipulations from his new carrier that he was forced to use after, for two years in a row his medical liability carrier left the state. (Dr. Ivan Castro, January 2003 academic task force report)
- Dr. Scott Posgai, a family practitioner in Orlando has stopped doing hospital admissions. (Dr. Scott Posagi, January 2003 academic task force report)
- Dr. Gregory Boger — Practice: Otolaryngology. Stopped seeing CMS children, and has restricted complexity of head, neck and ear cases. (Florida Medical Association affidavit)
- Dr. Ronald Burns — Practice: Family Practice. No longer provides fracture care, office surgical procedures, nursing home care or laceration repair, and has stopped treating pregnant women. (Florida Medical Association affidavit)
- Dr. Jeffrey Cohen — Practice: Nephrology. No longer performs kidney biopsies or catheter insertions, and limits scope of patient care as much as possible. (Florida Medical Association affidavit)
- Dr. R. Charles Curry — Practice: Cardiology. Performs additional diagnostic tests, and increases the length of hospital in-patient time. (Florida Medical Association affidavit)
- Dr. Clifford Dubbin — Practice: ENT Surgery. Stopped performing advanced head and neck cancer surgeries. (Florida Medical Association affidavit)
- Dr. Rory Evans — Practice: Orthopedic Surgery. Refers risky cases. (Florida Medical Association affidavit)
- Dr. Thomas Gibbs — Practice: OB/GYN. Stopped treating high-risk obstetrics patients, and refers gynecological patients away. (Florida Medical Association affidavit)
- Dr. Julio Gundian — Practice: Urology/KidneyTransplantation. Closed transplant program in Orlando, stopped seeing Medicaid patients, and is sending patients to ER. (Florida Medical Association affidavit)
- Dr. Richard Hall — Practice: Psychiatry. No longer treats severely psychotic or borderline personality patients, and has stopped in-patient care. (Florida Medical Association affidavit)

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- Dr. John Huhn — Practice: Otolaryngology. Diminished amount of patients with head and neck injuries. (Florida Medical Association affidavit)
- Dr. Roberto Lurcovich — Practice: OB/GYN. Can't see high-risk OB patients due to the cost of insurance. (Florida Medical Association affidavit)
- Dr. Dilys Jagger — Practice: Executive Director of Orlando Regional. Delays in care because of physicians stopping high-risk procedures, and increased cost in coverage. (Florida Medical Association affidavit)
- Dr. H. B. Karunaratne — Practice: Cardiology. Performs additional tests; increases inpatient hospital time, and consults other specialties. (Florida Medical Association affidavit)
- Dr. Nagui Khouzam — Practice: General Surgery. Couldn't afford the insurance, so is now without any. Wants all physicians to go without insurance. (Florida Medical Association affidavit)
- Dr. Mark Lagatta — Practice: Nephrology. Now referring patients to their primary care doctors or to the ER, and has stopped performing kidney transplants. (Florida Medical Association affidavit)
- Dr. Christie McMorrow — Practice: Neurosurgery. No longer carries malpractice insurance. (Florida Medical Association affidavit)
- Dr. Michael Mercado — Practice: Family/Geriatric. Has restricted nursing home and ALF practice. (Florida Medical Association affidavit)
- Dr. Matthew Mervis — Practice: OB/GYN. Has taken leave of absence. (Florida Medical Association affidavit)
- Dr. Mark Milunski — Practice: Cardiology. Performs additional diagnostic tests, and increases length of hospital time. (Florida Medical Association affidavit)
- Dr. George Monir — Practice: Cardiology. Performs additional diagnostic tests, and increases length of hospital time. (Florida Medical Association affidavit)
- Dr. Amr Morsi — Practice: Cardiology. Performs additional diagnostic tests, and increases length of hospital time. (Florida Medical Association affidavit)
- Dr. Elizabeth Nelson — Practice: Gynecology. Retired from obstetrics. (Florida Medical Association affidavit)
- Dr. John Papa — Practice: Orthopedic Surgery. Restricted number of second opinion patients who have had surgery performed elsewhere. (Florida Medical Association affidavit)
- Dr. Rakesh Patel — Practice: Urology/Renal Transplant. No longer performs kidney transplants, and no longer calls in prescriptions after hours. (Florida Medical Association affidavit)

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- Dr. Imogene White — Practice: OB/GYN. Only sees patients at one hospital. Will not allow patients with previous C-Sections to have trial of labor, they must have repeat C-Sections. (Florida Medical Association affidavit)
- Dr. David Vaughan — Practice: Urology. Has closed the kidney transplant program in Orlando because of the rising cost of malpractice premiums and the risk involved in caring for transplant patients. Has also stopped seeing Medicaid patients, stopped calling in most prescriptions over the phone and instead send patients to ER for after- hours problems. (Florida Medical Association affidavit)
- Dr. Maxine Tabes — Practice: Dermatology. At present, is strongly considering no longer seeing pediatric dermatology patients. In addition, is no longer caring for high-risk dermatology conditions. (Florida Medical Association affidavit)
- Dr. Raphael Tapia — Practice: Family Practice. Stopped serving patients in hospitals and nursing homes. Does not take critically ill patients. (Florida Medical Association affidavit)
- Dr. Jeffrey Thill — Practice: Urology. Stopped kidney transplantation, stopped seeing adult Medicaid due to liability issues. (Florida Medical Association affidavit)
- Dr. Ramon Torres — Practice: Cardiology. Has found it necessary to perform additional diagnostic tests, increases the length of hospital inpatient time, and consults other specialties as a way to minimize liability exposure. It is becoming increasingly difficult to find quality specialty consultants and primary care physicians to refer patients to. Group made the decision to cover only one hospital system in the Orlando area as a way to further decrease liability exposure. (Florida Medical Association affidavit)
- Dr. Douglas Sprung — Practice: Gastroenterology. Stopped ERCP, caring for Hepatitis C and Cirrhosis patients. (Florida Medical Association affidavit)
- Dr. Samuel Blick — Practice: Orthopedic Surgery. Stopped covering ER, and has stopped doing several high-risk surgeries. (Florida Medical Association affidavit)
- Dr. Alan Christensen — Practice: Orthopedic Surgery. Stopped ER calls at 3 hospitals, and no longer performs microvascularreplant surgeries. (Florida Medical Association affidavit)
- Dr. Raymond Bernstein — Practice: Gynecology. Stopped OB, and may discontinue GYN surgery. (Florida Medical Association affidavit)
- Dr. Stephen A. Butler — Practice: Urology. Is referring high-risk/complex cases to University Center, and stopped penile reconstruction procedures. (Florida Medical Association affidavit)
- Dr. Robert Murrah — Practice: Orthopedic Surgery. Stopped performing spine surgery, and is considering moving to another state. (Florida Medical Association affidavit)
- Dr. Gwinn Murray — Practice: Orthopedic Surgery. Retired. (Florida Medical Association affidavit)

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- Dr. Jorge Rodriguez — Practice: Orthopedic Hand Microsurgery. Stopped revision hip/knee surgeries, back surgeries, neck surgeries, and has limited pediatrics. (Florida Medical Association affidavit)
- Dr. Lawrence Halperin — Practice: Orthopedic Surgery. Stopped providing ER coverage, avoids high-risk surgeries, and doesn't accept acute trauma. (Florida Medical Association affidavit)
- Dr. Craig P. Jones — Practice: Orthopedic Surgery. Dropped ER calls at 4 hospitals, stopped general orthopedic surgery at one hospital system. (Florida Medical Association affidavit)
- Dr. G. Grady McBrike — Practice: Orthopedic Surgery. Stopped ER services to 3 hospitals, and stopped accepting transfers of spinal injury patients. (Florida Medical Association affidavit)
- Dr. D.S. Rotatori — Practice: Plastic Surgery. No difficult wounds, sternal osteop, breast reduct/hypertrophy, hidradenitis, pediatric. (Florida Medical Association affidavit)
- Dr. Tamara Topeleski — Practice: Pediatric Orthopedics. Has stopped ER coverage in 3 major hospitals. (Florida Medical Association affidavit)
- Dr. Stephen E. Weber — Practice: Orthopedic Surgery. Stopped emergency services coverage, and stopped accepting spine trauma patients. (Florida Medical Association affidavit)
- Dr. Randy Schwartzberg — Practice: Orthopedics. Has cut down ER call, and has stopped taking transfers & consults on patients with difficult fractures. (Florida Medical Association affidavit)
- OB & GYN Specialists, P.A. — After 25 years of practicing, the whole practice requested indefinite leaves of absence from medical staff at Florida Hospital, citing current liability crisis. This has necessitated an increased level of physician attendance during the course of labor, and has prohibited them from being able to practice at more than one hospital unless things change.
- Dr. Raymond Bernstein — Practice: Gynecology. Already stopped practicing OB; and is considering stopping GYN surgeries. (Florida Medical Association affidavit)
- Dr. Jeffrey Bott — Practice: Cardio/Thoracic Surgery. Intends to retire or leave, and no longer performs thoracic aortic or esophageal surgeries. (Florida Medical Association affidavit)
- Dr. Thomas Gibbs — Practice: OB/GYN. Stopped doing high-risk OB, and refers GYN patients away. (Florida Medical Association affidavit)
- Dr. Joshua Helman — Practice: Emergency Medicine. Only does volunteer work when he has sovereign immunity. (Florida Medical Association affidavit)

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- Dr. Matthew Meris — Practice: OB/GYN. Has taken leave of absence, probably permanently. (Florida Medical Association affidavit)
- Dr. Connie Micklavzina — Practice: OB/GYN. Is no longer seeing high-risk OB patients with high blood pressure, diabetes, heart disease. (Florida Medical Association affidavit)
- Dr. Gabriel Nuriel — Practice: Family Medicine. Stopped doing office-based procedures, and has quit doing private practice. (Florida Medical Association affidavit)
- Dr. John Olson — Practice: Ophthalmology. Plans to stop seeing retinopathy of prematurity patients. (Florida Medical Association affidavit)
- Dr. Robert S. Roberts — Practice: Orthopedic Surgery. No ER call; no high-risk procedures; no new worker's compensation surgical cases. (Florida Medical Association affidavit)
- Dr. Lawrence J. Shaffer — Practice: Emergency Medicine. Is moving to Charleston, SC. (Florida Medical Association affidavit)
- Dr. Mark Sinclair — Practice: Pediatric Orthopedics. Stopped doing a number of procedures—hand surgeries, and tumor surgeries on children. (Florida Medical Association affidavit)
- Dr. Ronald L. Woodburn — Practice: Radiology/Neuroradiology. Is retiring in December 2003 instead of 2006, and is limiting practice. (Florida Medical Association affidavit)
- Dr. Timothy Bullard — Practice: Emergency Medicine. Problems recruiting; shortages in various listed specialties. Specialties affected: Neurosurgery, Orthopedics, Vascular Surgery. (Florida Medical Association affidavit)
- Dr. Mark Clark — Practice: Emergency Medicine. Lack of hand surgeons, urologists, neurosurgeons. Specialties affected: Hand Surgery, Neurology, Neurosurgery, Obstetrics, Ophthalmology, Plastic Surgery, Urology. (Florida Medical Association affidavit)
- Dr. Jay Falk — Practice: Emergency Medicine. Physicians are increasingly reluctant to take call due to liability issues. Specialties affected: Burns, Cardiovascular Surgery, Gastroenterology, General Surgery, Hand Surgery, Neurosurgery Obstetrics, Ophthalmology, Orthopedics, Plastic Surgery, Urology, Vascular Surgery. (Florida Medical Association affidavit)
- Dr. Wayne Friestad — Practice: Emergency Medicine. Decreased number of specialists in OB, neurosurgery, orthopedics, and radiology willing to take ER call. Specialties affected: General Surgery, Gynecology, Hand Surgery, Neurosurgery, Obstetrics, Orthopedics, Urology. (Florida Medical Association affidavit)
- Dr. Philip Giordano — Practice: Emergency Medicine. High levels of malpractice cases and costs have made it more difficult to provide care to Level I trauma

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patients. Patients with critical needs for specialty care cannot be taken care of properly due to lack of specialists. Specialties affected: Emergency Medicine, General Surgery, Hand Surgery, Neurosurgery, Obstetrics, Ophthalmology, Oral/Maxillo-Facial Surgery, Orthopedics, Otolaryngology, Plastic Surgery, Trauma Care Center, Urology. (Florida Medical Association affidavit)

- Dr. Jorge Lopez — Practice: Emergency Medicine. Practice is in system comprised of seven hospitals in Orange, Osceola and Seminole counties. Our EDs have been crippled by the lack of on-call specialty care and closings of complete departments within individual hospitals. This has made vital services, like general surgery, obstetrics and gynecology, orthopedic surgery and neurosurgery unavailable, mandating the transfer of the affected patients to other facilities, at the peril of the patient while delaying timely care. Specialties affected: Cardiology, Emergency Medicine, General Surgery, Gynecology, Hand Surgery, Neurology, Neurosurgery, Obstetrics, Oral/Maxillo-Facial Surgery, Orthopedics, Otolaryngology, Pediatrics/Pediatric Surgery, Plastic Surgery, Psychiatry, Radiology, Thoracic Surgery, Urology, Vascular Surgery. (Florida Medical Association affidavit)
- Dr. Paula Mueller — Practice: Emergency Medicine. Coverage for hand and neurosurgery difficult, and access to care has been limited. This problem is ongoing; apparently difficult to recruit new physicians and keep older ones. This problem is escalating. Specialties affected: Hand Surgery, Neurosurgery, Urology. (Florida Medical Association affidavit)
- Dr. Ernest Page, II — Practice: Emergency Medicine. Only one neurosurgeon is on-call daily for 7 hospitals in system. There is no in-house general surgery coverage. All orthopedic and obstetric cases must be transferred along with all cases involving the following specialties. Specialties affected: General Surgery, Hand Surgery, Neurosurgery, Obstetrics, Orthopedics, Otolaryngology, Urology. (Florida Medical Association affidavit)
- Dr. William Poole — Practice: Emergency Medicine. Surgery availability is limited; often have to transfer; no cardiovascular, gastroenterology, neurosurgery or psychiatry, limited general, hand or pediatrics. The professional liability and litigation climate has had a significant impact on the availability of specialists. I have observed that specialists have become unavailable to the ED recently, where in the past the specialty coverage was excellent. This has resulted in delays, transfers and crowding of the ED awaiting specialists as well as potential risks to patients due to delays and transfers. Specialties affected: Burns, Cardiology, Cardiovascular Surgery, Gastroenterology, General Surgery, Hand Surgery, Neurosurgery, Pediatrics/Pediatric Surgery, Psychiatry, Thoracic Surgery, Urology. (Florida Medical Association affidavit)
- Dr. Aegan Schwartz — Practice: Emergency Medicine. Severe lack of specialists not willing to take call in our ED. Specialties affected: Burns, Gynecology, Hand Surgery, Neurology, Neurosurgery, Obstetrics, Oral/Maxillo-Facial Surgery, Orthopedics, Pediatrics/Pediatric Surgery, Plastic Surgery, Psychiatry, Radiology, Urology, Vascular Surgery. (Florida Medical Association affidavit)
- Dr. Salvatore Silvestri — Practice: Emergency Medicine. Decreased availability of neurosurgeons almost caused the Level I trauma center to close and actually still threatens the trauma center closing. Specialties affected: Hand Surgery, Neurosurgery. (Florida Medical Association affidavit)

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Osceola County

- Orlando Regional St. Cloud Hospital cut back on-call obstetrical/gynecology in the emergency department and eliminated vascular and urology coverage. (Orlando Regional St. Cloud Hospital, July 2003, FHA Survey)
- Dr. Christopher Baur — Practice: Family Practice. No longer performs vasectomies, or provides care for nursing home patients. (Florida Medical Association affidavit)
- Dr. Carmelita Nicdao — Practice: OB/GYN. Limited treating high-risk patients, and has resigned from 2 hospitals. (Florida Medical Association affidavit)
- Dr. Charles Powers — Practice: Family Practice. Stopped ER work, going to nursing homes, assisting with surgeries, and other surgeries. (Florida Medical Association affidavit)
- Dr. Joel Weinberger — Practice: Family Practice. Dropped pediatric privileges at the hospital locally. Uses hospitalists to admit all chest pain patients. Stopped going to nursing homes and treating pregnant women. (Florida Medical Association affidavit)
- Dr. John Wilker — Practice: Cardiology. Stopped going to nursing homes and deliveries. (Florida Medical Association affidavit)
- Dr. Paul Thorne — Practice: Family Practice. No longer doing nursing home visits. No surgical assisting. (Florida Medical Association affidavit)
- Dr. Bruce Yergin — Practice: Pulmonary Medicine. Not seeing high-risk patients if at all possible. Multiple additional consultants and multiple additional diagnostic testing is being done on many patients in order to cover potential litigation and this is driving up the costs of healthcare. (Florida Medical Association affidavit)
- Dr. Omar Fadhli — Practice: Otolaryngology. Stopped performing high-risk procedures. Patients must travel two hours to nearest teaching hospital. (Florida Medical Association affidavit)
- Dr. Patrick F. Mathias — Practice: Cardiology. Stopped seeing Medicaid patients. (Florida Medical Association affidavit)
- Dr. Leonardo Cisneros — Practice: Emergency Medicine. Recently lost two days of general surgery call per week; psychiatric patients may wait days to see psychiatrist; several hospitals share call for specialty services, resulting in specialists needed "stat" by one hospital ED being occupied at another hospital, thus delaying emergency care. Emergency physicians reluctant to work in hospitals with little specialty back-up availability. Specialties affected: Cardiology, Emergency Medicine, General Surgery, Gynecology, Internal Medicine, Neurosurgery, Obstetrics, Orthopedics, Pediatrics/Pediatric Surgery, Psychiatry. (Florida Medical Association affidavit)
- Dr. Vidor Friedman — Practice: Emergency Medicine. Common denominator is a lack of enough specialists to provide adequate coverage to the ED. This leads to frequent transfers of patients to other hospitals to obtain care. Specialties affected:

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Emergency Medicine, General Surgery, Gynecology, Neurosurgery, Obstetrics, Orthopedics, Pediatrics/Pediatric Surgery, Plastic Surgery, Psychiatry, Radiology. (Florida Medical Association affidavit)

Pasco County

- East Pasco Medical Center eliminated its on-call neurosurgery coverage in its emergency department. (East Pasco Medical Center, January 2003 FHA survey)
- Three thoracic/vascular surgeons refuse call at Morton Plant North Bay. (BayCare Health System, July 2003 FHA survey)
- Two general surgeons left the medical staff of East Pasco Medical Center, one retired early and the other joined staff at the VA hospital in Tampa. (East Pasco Medical Center, July 2003 FHA survey)
- East Pasco Medical Center's only neurosurgeon discontinued surgical procedures at the hospital due to high cost of malpractice insurance. (East Pasco Medical Center, July 2003 FHA survey)
- Two OB/GYNs discontinued on-call ER coverage and eliminated the obstetrical portion of their practice. (East Pasco Medical Center, July 2003 FHA survey)
- An otolaryngologist (ENT) closed his practice in Zephyrhills and moved to Texas. (East Pasco Medical Center, July 2003 FHA survey)
- East Pasco, two OB/GYNs – half the OB department – have dropped off staff because they were unwilling to pay the increased insurance premiums. (Rich Reiner, testimony, January 2003 academic task force report)
- Dr. Mark Eberbach — Practice: Plastic & Reconstructive Surgery. Stopped providing hand trauma care, immediate breast reconstruction, and wound & bedsore care. (Florida Medical Association affidavit)
- Dr. Lawrence Hochman — Practice: Radiation Oncology. Stopped pediatrics. (Florida Medical Association affidavit)
- Dr. Bruce Landon — Practice: Plastic/Reconstructive. No longer provides wound care, performs traumatic hand surgeries, treats facial trauma, and has limited breast reconstructive surgeries. (Florida Medical Association affidavit)
- Dr. Raymond Waters — Practice: Cardiac Surgery. Stopped certain surgeries and dropped staff privileges at two hospitals. Lost insurance carrier in December 2002 and can not get any insurance. (Florida Medical Association affidavit)
- Dr. Douglas Wert — Practice: Internal Medicine. Stopped seeing high-risk patients. (Florida Medical Association affidavit)
- Dr. Donald Vierling — Practice: Family Practice. Resigned from full-time family practice medicine. Now doing chronic wound care and hyperbaric medicine on a part-time basis. (Florida Medical Association affidavit)

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- Dr. John Shim — Practice: Spinal Surgery. Stopped performing high-risk surgeries and treating worker's compensation patients. (Florida Medical Association affidavit)
- Dr. Sudhir Agarwal — Practice: Internal Medicine/Cardiology. Stopped seeing high-risk patients with multiple medical problems. (Florida Medical Association affidavit)
- Dr. Usha Agarwal — Practice: Internal Medicine. Stopped seeing high-risk patients with multiple medical problems. (Florida Medical Association affidavit)
- Dr. Aziz Alkafaji — Practice: General/Vascular Surgery. Stopped seeing patients under 16-years old, and stopped high-risk surgeries. (Florida Medical Association affidavit)
- Dr. Charles Anthony — Practice: Diagnostic Radiology. May retire sooner, and has stopped doing astriograms. (Florida Medical Association affidavit)
- Dr. James K. Condon — Practice: Thoracic,Vasc,Gen Surgery. Stopped seeing Medicaid patients, and has stopped performing pancreatic & aortic surgeries. (Florida Medical Association affidavit)
- Dr. Gaither Davis — Practice: Otolaryngology. Stopped doing high-risk procedures. (Florida Medical Association affidavit)
- Dr. Robert L. Jr. Duncan, Jr. — Practice: Internal Medicine. Stopped minor surgical procedures, and is deferring many minor problems to specialists. (Florida Medical Association affidavit)
- Dr. John R. Hamill, Jr— Practice: Dermatology-Skin Cancer. Refers some skin cancers to other specialists; no children/pregnant women; no new technologies. (Florida Medical Association affidavit)
- Dr. Maynard Taylor — Practice: Thoracic Surgery. Retired. (Florida Medical Association affidavit)
- Dr. Russell Bain — Practice: Pediatrics. Owns a 5-doctor group. Does not see indigent patients, is unable to buy up-to-date equipment, and has had to reduce staffing. (Florida Medical Association affidavit)
- Dr. Diane Normandin — Practice: Family Practice. Moved to another country. (Florida Medical Association affidavit)
- Dr. Maxwell Rent — Practice: Gastroenterology. Avoids ER call, and has cut back on number of referrals. (Florida Medical Association affidavit)
- Dr. Raymond S. Waters — Practice: Cardiovascular & Thoracic. Has dropped privileges at North Bay Hospital, and has stopped certain thoracic and aortic surgeries. (Florida Medical Association affidavit)

Pinellas County

- Largo Medical Center eliminated its obstetrical unit. (Largo Medical Center, January 20003 FHA survey)

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- Largo Medical Center - general/vascular surgeon is on leave of absence, unable to obtain insurance. (Largo Medical Center, July 2003 FHA survey)
- Largo Medical Center - general/vascular surgeon closed his practice due to malpractice premiums. (Largo Medical Center, July 2003 FHA survey)
- Largo Medical Center - Internal medicine/family practice physician practice closed and physicians moved practice to Tennessee, unable to obtain affordable insurance. (Largo Medical Center, July 2003 FHA survey)
- Largo Medical Center - Family Practice physician is on leave of absence, unable to obtain insurance. (Largo Medical Center, July 2003 FHA survey)
- At least four OB/GYNs have left. (BayCare Health System, July 2003 FHA survey)
- One gastroenterologist has left. (BayCare Health System, July 2003 FHA survey)
- One neurosurgeon has left the area. (BayCare Health System, July 2003 FHA survey)
- A general/vascular surgeon will be leaving the state soon. (BayCare Health System, July 2003 FHA survey)
- ENT specialists are refusing to cover BayCare ERs. They are unable to recruit neurosurgeons without covering insurance. (BayCare Health System, July 2003 FHA survey)
- Dr. J. A. Arnold — Practice: Neurology. Insurance companies don't want to pay his PIP claims; SB 1092 put him out of business. (Florida Medical Association affidavit)
- Dr. Scott Beck — Practice: Pediatric Orthopedics. Limited practice and ability to treat all children. (Florida Medical Association affidavit)
- Dr. Beth Benson — Practice: OB/GYN. Declines certain patients. Has stopped delivering babies for Medicaid patients. Is considering stopping obstetrics. (Florida Medical Association affidavit)
- Dr. Brett Bolhufner — Practice: Orthopedic Surgery. Decreased emergency services. Trauma center will close this year if there is no reform. (Florida Medical Association affidavit)
- Dr. Christine Burns — Practice: Pediatric Ophthalmology. Cut malpractice insurance to bare minimum. (Florida Medical Association affidavit)
- Dr. George Burns — Practice: Dermatology. Has limited procedures. (Florida Medical Association affidavit)
- Dr. Jeffrey Carlson — Practice: OB/GYN. No longer performing high-risk or complicated OB/GYN procedures. Will stop practice as of 6/30/04. (Florida Medical Association affidavit)

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- Dr. Harold Colbassani — Practice: Neurosurgery. Stopped aneurysm surgery, complex trauma surgery, and treatment of spinal fractures. (Florida Medical Association affidavit)
- Dr. Carmen Damiani — Practice: OB/GYN. Stopped gynecological care for state-funded insurances; reduced number of major surgeries. (Florida Medical Association affidavit)
- Dr. Philip Davidson — Practice: Orthopedics. No longer sees or operates on trauma patients, and has dropped ER call and charity cases. (Florida Medical Association affidavit)
- Dr. Mark Gordon — Practice: Urology. Will not perform high-risk surgeries, and will not see patients who have had complications. (Florida Medical Association affidavit)
- Dr. Gregory Hahn — Practice: Pediatric Orthopedics. Restricts practice by restricting some diagnoses, and has limited practice. (Florida Medical Association affidavit)
- Dr. Robert Hamilton — Practice: Orthopedics. Does not perform neck or spinal surgery, and is ready to move. (Florida Medical Association affidavit)
- Dr. George Harris — Practice: Family Practice. Stopped performing high-risk procedures. (Florida Medical Association affidavit)
- Dr. Ronald Hayter — Practice: Orthopedic Surgery. No longer treats trauma or workers compensation patients. (Florida Medical Association affidavit)
- Dr. Jeffrey Karp — Practice: Neurology. Curtailed Medicare; no Medicaid; no workers comp; signed off of several medical HMOs. (Florida Medical Association affidavit)
- Dr. John Kilgore — Practice: Orthopedic Surgery. No longer sees workers comp & personal injury patients, and refers complicated pediatric injuries. (Florida Medical Association affidavit)
- Dr. William LaRosa — Practice: Urology. Avoiding performing open procedures, seeing ER patients, and is considering early retirement. (Florida Medical Association affidavit)
- Dr. Philip Lerner — Practice: General Surgery. Has chosen early retirement. May practice elsewhere in the future. (Florida Medical Association affidavit)
- Dr. Owen Linder — Practice: Internal Medicine. Does not accept all applicants for care. (Florida Medical Association affidavit)
- Dr. Sheila Love— Practice: Pediatric Orthopedics. Restricted practice, and has stopped performing high-risk procedures and seeing certain types of patients. (Florida Medical Association affidavit)

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- Dr. William Lowry — Practice: Orthopedic Surgery. Discontinued spinal surgery and procedures, and is prepared to move out of state. (Florida Medical Association affidavit)
- Dr. John McClure — Practice: Orthopedic Surgery. No longer covers ER calls. (Florida Medical Association affidavit)
- Dr. Edward Mackay — Practice: General/Vascular Surgery. No longer does ER calls or performs major surgeries. (Florida Medical Association affidavit)
- Dr. Jeffrey Neustadt — Practice: Pediatric Orthopedics. Stopped performing high-risk procedures, and has stopped seeing certain types of patients. (Florida Medical Association affidavit)
- Dr. John O'Brien — Practice: Plastic Surgery. Stopped ER calls. (Florida Medical Association affidavit)
- Dr. Norman Urich — Practice: Family Practice. Stopped highly litigious practices and patient care. (Florida Medical Association affidavit)
- Dr. Debra Thomas — Practice: Ophthalmology. Refers all high-risk cateract surgeries to another surgeon who is willing to do them. Have been sued twice, lost malpractice, forced to use JUA for a year. Was investigated and fined, and has considered retiring at age 53. (Florida Medical Association affidavit)
- Dr. Paul Schorr — Practice: Family Practice. Moving to Texas. Won't do OB, hospital or nursing home work or office-based surgical procedures. (Florida Medical Association affidavit)
- Dr. Lewis Apter — Practice: Ophthalmology. Considering stopping all ER coverage due to liability. (Florida Medical Association affidavit)
- Dr. George H. Canizares — Practice: Orthopedic Surgery. Stopped doing some kinds of joint surgeries & other high-risk procedures. (Florida Medical Association affidavit)
- Dr. Steven Myles Cohen — Practice: Ophthalmology. Stopped covering ER at Morton Plant and St. Anthony's Hospital for ophthalmology. (Florida Medical Association affidavit)
- Dr. George H. Coupe — Practice: Family Practice & Aviation. Almost completely stopped family practice patients, minor surgery & manipulation. (Florida Medical Association affidavit)
- Dr. Clinton B. Davis — Practice: Orthopedic Surgery. Stopped neck surgery & any high-risk spinal deformity procedures; may stop trauma. (Florida Medical Association affidavit)
- Dr. John B. DeConnell — Practice: Family Practice. No surgery (major or minor), and no invasive office procedures. (Florida Medical Association affidavit)

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- Dr. Charles Finn — Practice: Orthopedic Surgery. No longer performs complicated cases of the spine (adult scoliosis). (Florida Medical Association affidavit)
- Dr. David McKalip — Practice: Neurology. Sends complex tumors and aneurysms to university, and no pediatric neurosurgery. (Florida Medical Association affidavit)
- Dr. Sheila Devanesan — Practice: OB/GYN. Has limited high-risk patients, and may have to stop midwife services. (Florida Medical Association affidavit)
- Palms of Pasadena Hospital — Several general surgeons left state. With only 4 general surgeons left, coverage in ER may be compromised due to them having to cover other hospitals too. Unable to recruit due to crisis. Busiest neurosurgeon has resigned, and another suspended his practice due to crisis. No longer can offer 24/7 neurosurgery coverage in ER. (Florida Hospital Association affidavit)
- Largo Medical Center — OB services dropped. Physicians on staff have had to relocate or retire due to increased malpractice insurance costs. (Florida Hospital Association affidavit)
- Dr. Robert Smith Howard — Practice: Radiology. No more mammography due to risk & cost of malpractice insurance. (Florida Hospital Association affidavit)
- Dr. John Dodson — Practice: Emergency Medicine. Hospital has no new surgeons in past 5 years, while 1 surgeon restricted practice then left state; 1 surgeon currently trying to leave area; 1 surgeon restricted practice and will not see trauma; 2 surgeons restricted practice and will not see pediatrics; Neurosurgery—available only 1 week out of 3. In past 3 years, 1 neurosurgeon moved out of state and 1 retired; no hand surgeons—all patients transferred. OB unit closed in 2002, no oral surgery coverage, only 2 weeks per month of plastic surgery coverage, psychiatrist will not take ER call. No new urologists. In past 4 years, 2 urologists have retired and 1 has moved. A Pinellas emergency physician is concerned about decline in available specialists, difficulty in obtaining specialist coverage and the impact on the growing number of elderly patients with complex problems. Emergency care is a double burden on specialists. Not only is the specialist unable to see his own scheduled patients, but he is needed to provide ER care. Not only does he lose income, but he has to purchase malpractice insurance to cover his care for ER patients. Lack of back up specialist care is beginning to severely threaten the safety net of emergency care. It has the effect of forcing emergency physicians to practice at or beyond the limits of their competence just to provide temporary care, or force patient to be transferred and/or have their care excessively delayed. This unfortunately results in a general deterioration of emergency care at a time when we need it more than ever. Specialties affected: General Surgery, Hand Surgery, Neurosurgery, Obstetrics, Ophthalmology, Oral/Maxillo-Facial Surgery, Plastic Surgery, Psychiatry, Urology. (Florida Medical Association affidavit)
- Dr. Terry Meadows — Practice: Emergency Medicine. In my region there have been multiple closures of OB units. There is very restricted coverage of neurosurgery, which varies day by day. Neurologists are not available to take call and evaluate an acute stroke for possible thrombolysis in Palm Beach County. Hand, plastic and otolaryngology are almost nonexistent in the community hospitals of West Central Florida. Presently there are multiple facilities facing resignations from staff of orthopedics and general surgeons. These specialties are necessary to

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be able to provide emergency care. Specialties affected: Hand Surgery, Neurology, Neurosurgery, Obstetrics, Ophthalmology, Oral/Maxillo-Facial Surgery, Otolaryngology, Plastic Surgery. (Florida Medical Association affidavit)

Polk County

- Three physicians at Regency Medical Center stopped practicing obstetrics, limiting their practice to gynecology patients in the last year. (Regency Medical Center, July 2003 FHA survey)
- Dr. Gordon Rafool's partner at a multi-specialty clinic in Winter Haven has given up obstetrics and all of them have stopped doing any high-risk procedures. (Dr. Gordon Rafool, January 2003 academic task force report)
- Dr. John Amann — Practice: Neurosurgery. Not treating pediatric patients, patients with certain brain and spinal cord tumors or aneurysms. (Florida Medical Association affidavit)
- Dr. Matthew Joseph Cory — Practice: Pediatrics/General. Stopped attending C-sections and high-risk deliveries; stopped treating sick newborns. (Florida Medical Association affidavit)
- Dr. Herminio Cuervo-Delgado — Practice: Neurology. Refuses to see high-risk patients, and looking at other options. (Florida Medical Association affidavit)
- Dr. Paul Dowdy — Practice: Orthopedic Surgery. Restricts ER coverage. (Florida Medical Association affidavit)
- Dr. Masuo Koike — Practice: OB/GYN. Stopped obstetrics. (Florida Medical Association affidavit)
- Dr. Daniel Leviten— Practice: Pediatrics. Does more lab studies, and is more likely to refer patients to specialists. (Florida Medical Association affidavit)
- Dr. J. Anthony Mancini — Practice: OB/GYN. Limits high-risk obstetrical patients, and limit certain surgeries. (Florida Medical Association affidavit)
- Dr. Thomas McClane — Practice: Psychiatry. Stopped giving ECT and stopped all hospital practice. (Florida Medical Association affidavit)
- Dr. Jesse Morgan— Practice: Orthopedic Surgery. Stopped performing MVA, polytrauma, revision orthoplasty, and hand injury procedures, and stopped treating workers compensation patients. (Florida Medical Association affidavit)
- Dr. David Murray — Practice: Dermatology. Stopped performing high-risk procedures, and will attempt self-insurance. (Florida Medical Association affidavit)
- Dr. Ricardo Perez — Practice: Family Practice. Stopped doing flex sigs and minor surgical procedures, and stopped seeing Medicaid patients. (Florida Medical Association affidavit)

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- Dr. John Pucket — Practice: Gynecology. No longer deliver babies or performs surgery. (Florida Medical Association affidavit)
- Dr. Gordon Rafool — Practice: Geriatrics. Restricted number of patients and sees no trauma patients. (Florida Medical Association affidavit)
- Dr. Shailesh Rajguru — Practice: Neurology. Doesn't see workers compensation, high-risk, or complex neurological patients. (Florida Medical Association affidavit)
- Dr. Ponnavolu Reddy — Practice: Orthopedic Surgery. Stopped performing high-risk procedures. (Florida Medical Association affidavit)
- Dr. Ayanna Rolette — Practice: Pediatrics. Runs more tests and sends more patients to specialists. (Florida Medical Association affidavit)
- Dr. John Susac — Practice: Neurology. Stopped seeing emergency room and inpatient hospital patients. (Florida Medical Association affidavit)
- Dr. Herbert W. Acken — Practice: OB/GYN. Stopped seeing OB patients. (Florida Medical Association affidavit)
- Dr. Jose Martinez-Salas — Practice: Internal Medicine. Discourages colleagues from referring high-risk OB patients. (Florida Medical Association affidavit)
- Dr. Peter S. Verrill — Practice: OB/GYN. Stopped OB as of 1/2/03 and stopped performing higher-risk GYN surgery. (Florida Medical Association affidavit)
- Dr. David B. Simmons — Practice: Gastroenterology. Stopped performing procedures he used to perform a large volume of due to liability risk. (Florida Medical Association affidavit)

Sarasota County

- Doctors Hospital of Sarasota eliminated its obstetrical unit. (Doctors Hospital of Sarasota, January 2003 FHA survey)
- Sarasota Memorial Hospital eliminated its on-call neurology coverage in its emergency department. (Sarasota Memorial Hospital, January 2003 FHA survey)
- Dr. William Belmont — Practice: Ophthalmology. Not performing retinal detachment surgery, among others. (Florida Medical Association affidavit)
- Dr. Adam Bright — Practice: Orthopedic Surgery. Stopped performing spine surgery, stopped accepting Medicaid unless through ER. (Florida Medical Association affidavit)
- Dr. William Eaton — Practice: Family Practice. Looking to stop hospital care. Difficult to find specialists to whom he can refer business. (Florida Medical Association affidavit)

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- Dr. Michael Feiertas — Practice: Orthopedic & Spine. Stopped ER calls, cocyglectomy, and revision total joints replacements. (Florida Medical Association affidavit)
- Dr. Bruce Fleegler — Practice: Pulmonary/Critical Care. Stopped critical care. (Florida Medical Association affidavit)
- Sarasota Memorial Healthcare System — We are the only hospital in the county performing deliveries. Our hospital will lose $2 million on this service in 2003. (Florida Hospital Association affidavit)
- Dr. David Gooding — Practice: Family Practice. Stopped certain minor office surgeries due to increased malpractice premiums. (Florida Medical Association affidavit)
- Dr. John Hand — Practice: Orthopedic Surgery. Stopped seeing workers compensation patients, and tries to avoid performing high-risk procedures. (Florida Medical Association affidavit)
- Dr. Lawrence Hurvitz — Practice: Ophthalmology. Turns away patients with advanced glaucoma and declines operating on them. (Florida Medical Association affidavit)
- Dr. Michael Jaquith — Practice: Orthopedic Surgery. Stopped ER calls, high-risk joint repair, fracture care, and shoulder replacement surgeries. (Florida Medical Association affidavit)
- Dr. Gerald John — Practice: Internal Medicine. Stopped seeing patients with no physicians in the ER, and stopped taking call at hospital. (Florida Medical Association affidavit)
- Dr. Robert Lastomirsky — Practice: Internal Medicine. Will need to stop seeing nursing home patients due to insurance and risks. (Florida Medical Association affidavit)
- Dr. Richard Wilhelm — Practice: General Surgery. In addition to the changes in his practice status, because charitable organizations can continue rendering professional medical services only with liability protection, he has been forced to totally stop donating his professional services to all these organizations because of the prohibitive cost of malpractice coverage which neither he nor the organizations can afford. As a result thousands of needy patients are being denied services. (Florida Medical Association affidavit)
- Dr. Christine Shoub — Practice: Anesthesiology. As of April 03, her medical malpractice cost increased 50%. Reduced her practice and no longer treats chronic pain patients. Also, no longer has coverage in 6 Florida counties. (Florida Medical Association affidavit)
- Dr. Michael Swor — Practice: OB/GYN. Trained and certified in high-risk gynecology surgery and OB. Does not practice either because of the risk of liability and the cost of malpractice insurance. (Florida Medical Association affidavit)

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- Dr. Bram Riegel — Practice: Physical Medicine/Rehab. Performs no invasive procedures. (Florida Medical Association affidavit)
- Dr. William Letson — Practice: General Surgery. Stopped doing radical and high-risk procedures. (Florida Medical Association affidavit)
- Dr. John Paul Vidalin — Practice: Orthopedic Surgery. Stopped seeing high-risk patients, no longer performs difficult surgeries, and may leave state. (Florida Medical Association affidavit)
- Dr. Steven Newman — Practice: Emergency Medicine. Cannot obtain malpractice coverage as Sarasota EMS Medical Director—has to give up job held since 1974. Specialty affected: EMS Medical Direction. (Florida Medical Association affidavit)

Seminole County

- Orlando Regional South Seminole Hospital eliminated its on-call neurology coverage in its emergency department. (Orlando Regional South Seminole Hospital, January 2003 FHA survey)
- Five OB/GYNs resigned from Central Florida Regional Medical Center's staff effective August 1, leaving only four on staff. Discussions now going on to close OB unit. Their only neurosurgeon has resigned. (Central Florida Regional Hospital, July 2003 FHA survey)
- Dr. Jon D. Wiese, a general surgeon in Longwood has stopped doing some surgical procedures and is contemplating leaving the state. (Dr. Jon Wiese, January 2003 academic task force report)
- Dr. Dennis Abraham — Practice: Family Practice. No longer sees new Medicare patients, and doesn't see patients without insurance. (Florida Medical Association affidavit)
- Dr. Narinder Aujla — Practice: Orthopedics. Stopped performing back and hand surgeries. (Florida Medical Association affidavit)
- Dr. Jay Bitar — Practice: Cardiology. Stopped taking ER calls, and stopped seeing Medicaid patients. (Florida Medical Association affidavit)
- Dr. Anthony Cappola — Practice: Gastroenterology. Stopped performing liver biopsies, and decreased number of Hepatitis C patients. (Florida Medical Association affidavit)
- Dr. Richard Feibelman — Practice: Pulmonary. Seeing fewer critical care patients; performing fewer high-risk procedures. (Florida Medical Association affidavit)
- Dr. Anthony Lin — Practice: Gastroenterology. Reduced number of feeding tubes placed, and no longer performs liver biopsies. (Florida Medical Association affidavit)
- Dr. Aravind Pillai — Practice: Internal Medicine. Stopped performing echocardiographies, stress tests, and minor surgeries in office. (Florida Medical Association affidavit)

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- Dr. David Poole — Practice: Plastic/Reconstructive Surgery. Stopped taking insurance- based patients, and limits exposure to low-risk patients. (Florida Medical Association affidavit)
- Dr. Raul Tamayo — Practice: Internal Medicine. Does not admit patients to hospital. (Florida Medical Association affidavit)
- Dr. George V. Cestaro — Practice: Family Practice. Quit admitting to hospital to reduce risk, and will retire soon and leave state to work. (Florida Medical Association affidavit)
- Dr. Clyde H. Climer — Practice: OB/GYN. Gave up OB, and is practicing without professional liability coverage. No more Medicaid. (Florida Medical Association affidavit)
- Dr. Glen Davis — Practice: Internal Medicine. Stopped ER call, going to nursing homes, certain procedures, and seeing some patients. (Florida Medical Association affidavit)
- Dr. Jorge Gomez-Amador — Practice: Internal Medicine. Stopped pacemaker insertions, certain catheter insertions, and restricts ER calls. (Florida Medical Association affidavit)
- Dr. Jesse Johnson — Practice: Internal Medicine. No longer sees Medicare patients, doesn't accept patients without insurance, and is looking outside of state. (Florida Medical Association affidavit)
- Dr. Miguel Lugo — Practice: Ophthalmology. Stopped taking ER call at hospital, and stopped seeing patients injured in auto accidents. (Florida Medical Association affidavit)
- Dr. Kahang Chan — Practice: Emergency Medicine. No in-house orthopedic on-call coverage 50% of time, requiring transfer of patients. Shortage of neurosurgery coverage, resulting in transfers and delaying care for life-threatening neurosurgical emergencies. Lack of orthopedic call compromises trauma care. Specialties affected: Orthopedics, Neurosurgery, Trauma Care Center. (Florida Medical Association affidavit)

St. Lucie County

- Dr. Jeffrey Brown — Practice: Oral/Maxillofacial Surgery. Stopped performing cancer-related surgeries; decreased trauma coverage. (Florida Medical Association affidavit)
- Dr. Rogelio Gonzalez — Practice: Family Practice. Retired on 12-28-02 because of high malpractice. (Florida Medical Association affidavit)
- Savannas Hospital — A neurologist and a family practitioner have relinquished their privileges at our facility due to escalating malpractice coverage costs for in-hospital practice. (Florida Hospital Association affidavit)

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Volusia County

- Halifax Medical Center in Daytona Beach is struggling to maintain Level 2 trauma services due to staffing concerns. Surgical Associates agreed to provide full Trauma Unit support through the Legislative Sessions or at least until the end of August, whichever comes first. They remain highly concerned and committed to reducing their exposure if the Legislature fails to act in a way that will hold the promise of reduced medical liability premiums. (Halifax Medical Center, July 2003 FHA survey)
- Radiology Associates notified Halifax Medical Center that it would no longer read mammograms after August 1. As many as 70 women each day — or 17,000 each year — in Volusia County may be denied screening mammograms. (*Daytona Beach News-Journal*, May 9, 2003)
- Specialty coverage for emergency and/or trauma care has compromised the provision of emergency/trauma care in the following specialty areas: Cardiovascular Surgery, General Surgery, Gynecology, Neurosurgery, Obstetrics, Ophthalmology, Otolaryngology, Pediatrics/Pediatric Surgery, Psychiatry, Radiology, Trauma Center Care. (Florida College of Emergency Physicians affidavit)
- This reporting emergency physician indicates Florida Hospital Fish Memorial has recently experienced a major decrease in the number of privileged OB/GYN physicians to the point where the emergency room at Fish Memorial is no longer able to offer 24/7 coverage. There is no obstetrics department at this hospital whose service area includes both the largest city in Volusia County (Deltona), and the fastest growing city in Volusia County. (Florida College of Emergency Physicians affidavit)
- Reporting emergency physician indicates that there is no pediatric department at the affected Volusia County hospital. Sick pediatric patients must be transferred to one of the two tertiary care hospitals in Orlando. Bed available for these transfer patients at the accepting facilities is frequently scarce and, consequently, sick pediatric patients, who, otherwise, would require intensive pediatric care services, must be managed in the local emergency room. (Florida College of Emergency Physicians affidavit)
- Reporting emergency physician indicates that general surgery coverage reached a crisis several months ago, when a very active three person surgical practice had to quit practicing temporarily because they could not afford to pay for professional liability insurance. The group subsequently resumed practice, but has pulled out of practice at the affected hospital. The emergency physician understands that another two-person surgery practice based in Deland is also planning to cease practice at the hospital. (Florida College of Emergency Physicians affidavit)
- Neurosurgery coverage is non-existent at Fish Memorial. (Florida College of Emergency Physicians affidavit)
- Ophthalmology and ENT coverage present a problem in that there are no such physicians on staff at the neighboring hospital in Deland. Consequently, whenever a patient with an eye, ear, nose or throat problem presents to the affected hospital, the patient must be transferred. (Florida College of Emergency Physicians affidavit)

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- Reporting emergency physician indicates that there is no psychiatry coverage for the ER at Fish Memorial. (Florida College of Emergency Physicians affidavit)
- Reporting emergency physician states that trauma services in Volusia County are "hanging by a thread" as the trauma surgeons at Halifax Medical Center have publicly stated their intention to stop seeing trauma patients if they do not obtain relief from the medical malpractice crisis soon. (Florida College of Emergency Physicians affidavit)
- Dr. Frank Denoff — Practice: Orthopedic Surgery. Stopped treating complicated trauma injuries, reconstructive cases, and pediatric cases. (Florida Medical Association affidavit)
- Dr. Humberto Dominguez — Practice: Family Practice. Stopped treating emergency room patients. (Florida Medical Association affidavit)
- Dr. Harold Fenster — Practice: General Surgery. Taken three-month leave of absence, and has restricted practice to low-risk patients. Also stopping Medicaid. (Florida Medical Association affidavit)
- Dr. Mark Harr — Practice: Orthopedic Surgery. Stopped treating trauma patients, performing high-risk surgeries, etc. (Florida Medical Association affidavit)
- Dr. Kenneth Hawthorne — Practice: Orthopedic Surgery. Cut back trauma call; very selective in new patients, and will not perform difficult procedures. (Florida Medical Association affidavit)
- Dr. Mark Hollmann — Practice: Orthopedic Surgery. Stopped revision hip surgery, has limited number of back patients, and stopped performing foot and ankle surgeries. (Florida Medical Association affidavit)
- Dr. Royce Hood — Practice: Orthopedics. Considering not treating pediatric patients, or performing specific surgeries. (Florida Medical Association affidavit)
- Dr. Jon Jackson — Practice: Family Practice. Stopped hospital practice. (Florida Medical Association affidavit)
- Dr. Thomas Kropp — Practice: Plastic/Reconstructive Surgery. No longer accepts patients that require complex surgery. (Florida Medical Association affidavit)
- Dr. Stephanie Lavoie — Practice: Orthopedic Surgery. Avoids trauma surgery. (Florida Medical Association affidavit)
- Dr. Magdy Nashed — Practice: Internal Medicine. No longer accepts HMO (additional) patients, and doesn't see patients who have sued other doctors. (Florida Medical Association affidavit)
- Dr. Robert Quelette — Practice: OB/GYN. Stopped practicing obstetrics. (Florida Medical Association affidavit)

- Dr. John Walker — Practice: Cardiology. Stopped seeing unassigned patients at Halifax Medical Center. (Florida Medical Association affidavit)
- Dr. GG Telesh — Practice: Orthopedic Surgery. Discontinued ER trauma coverage, discontinued high-risk procedures and joint replacements and cases that don't have excellent recovery potential. (Florida Medical Association affidavit)
- Dr. John Turner — Practice: Family Practice. Stopped seeing patients in the hospital, and dropped all worker's compensation patients. (Florida Medical Association affidavit)
- Dr. Margaret M. Chang — Practice: Family Practice. Small town hospital lost 1 of 2 nephrologists, and 1 of 2 cardiologists. More tests are run. (Florida Medical Association affidavit)
- Dr. Carlos Dominguez — Practice: Internal Medicine. No more nursing home care, minor surgical procedures at office or Medicaid patients. (Florida Medical Association affidavit)
- Dr. W. Ross Mayfield — Practice: Anesthesiology. Limiting the use of certain procedures that are high-risk. (Florida Medical Association affidavit)
- Dr. Ratan Ahuja — Practice: Cardiovascular Disease. Restricted to 2 hospitals, and has stopped seeing OB patients with cardiovascular problems.

NORTHERN FLORIDA

Alachua County

- There is no longer a physician doing pain management full time. (Alachua County Medical Society, July 2003 FHA survey)
- Nephrologists have stopped doing biopsies. (Alachua County Medical Society, July 2003 FHA survey)
- North Florida Regional Medical Center has lost one obstetrician and the only non-interventional cardiologist. A large general surgery group is now requesting all patients to sign arbitration agreements prior to surgery. (North Florida Regional Medical Center, July 2003 FHA survey)
- Dr. Patricia Fearing — Practice: OB/GYN. No longer practices obstetrics. (Florida Medical Association affidavit)
- Dr. Gordon Finlayson — Practice: Nephrology. Stopped performing renal biopsies, and no longer is following kidney transplants. Primary care to dialysis. (Florida Medical Association affidavit)
- Dr. Michael Lukowski — Practice: OB/GYN. Will stop treating Medicaid patients. (Florida Medical Association affidavit)

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- Dr. Darrell Tarrant — Practice: Nephrology. Stopped performing renal biopsies, seeing renal transplant patients, and stopped providing primary care to dialysis patients. Plans to retire sooner than planned. (Florida Medical Association affidavit)
- Dr. Angeli M. Akey — Practice: Internal Medicine. Stopped laser-based and asthetic procedures, and working is extra job to afford premium. (Florida Medical Association affidavit)
- Dr. Anne E. Dickison — Practice: Anesthesiology/Pediatrics. Forced to work locum tenens—resides in Florida, but mostly commutes to other states. (Florida Medical Association affidavit)
- Dr. Rosi Fortunato — Practice: Pediatrics. Decreased hours, and stopped attending deliveries and stabilizing sick newborns. (Florida Medical Association affidavit)

Bay County

- Dr. Yvonne Bullard — Practice: OB/GYN. No longer delivers babies or accepts new patients. (Florida Medical Association affidavit)
- Dr. Hulon Crayton — Practice: Rheumatology. Stopped performing high-risk procedures. (Florida Medical Association affidavit)
- Dr. James DeRuiter — Practice: OB/GYN. Stopped seeing uncooperative patients. Had to self-insure. Refers a lot of cases elsewhere. (Florida Medical Association affidavit)
- Dr. Michael Reed — Practice: Orthopedic Surgery. Stopped seeing Medicaid and limited Medicare, stopped some high-risk procedures. (Florida Medical Association affidavit)
- Dr. Myra Reed — Practice: Internal Medicine. No longer assisting in surgery, and not covering ER. (Florida Medical Association affidavit)
- Dr. Michael Rohan — Practice: Orthopedic Surgery. Stopped ER coverage, and high increase in use of defensive medicines. (Florida Medical Association affidavit)
- Dr. Mark Williams — Practice: Orthopedic Surgery. Has stopped taking emergency room call and other traumatic related problems. Has also stopped performing certain orthopedic surgical procedures associated with high-risk such as fracture surgery and total hip replacement. (Florida Medical Association affidavit)
- Dr. Quang Tran — Practice: Head & Neck Surgery. Will not perform certain surgeries. Will not perform cosmetic and facial reconstructive surgeries. (Florida Medical Association affidavit)
- Dr. Robert Briskin — Practice: Internal Medicine. No longer admits managed care patients to the hospital, and may drop off active medical staff. (Florida Medical Association affidavit)
- Dr. Frederick Epstein — Practice: Emergency Medicine. Emergency physician group lost insurance coverage, first due to financial failure and bankruptcy of the insurer, then second insurer refused renewal of policy, reporting that the climate in

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Florida was too adverse. Group is now "bare". There are three plastic surgeons in the community; one has resigned privileges at this hospital. There are three oral/maxillo-facial surgeons practicing in the community; all three refuse to practice at this hospital. ER currently relies on otolaryngologist. Of six otolarygologists in the community, two have resigned privileges at this hospital. Only two of six hand surgeons will practice at hospital. Entire group of eight orthopedists resigned privileges. Hospital has temporarily addressed the problem. Problem of emergency call in this situation is a "business decision." Hospital is a public hospital with sovereign immunity. When litigation results, these physicians become the exclusive and collective "deep pocket." Specialties affected: Emergency Medicine, Hand Surgery, Oral/Maxillo-Facial Surgery, Orthopedics, Otolaryngology, Plastic Surgery. (Florida Medical Association affidavit)

Clay County

- Orange Park obstetrician Charles Wison can no longer deliver babies because he can't find a company to insure him. The company that insured him last year left the state. (*Florida Times-Union*, April 2, 2003)
- Dr. William Choisser — Practice: Family Practice. Lost one doctor out of a group; resigned from the hospital, cannot afford insurance. (Florida Medical Association affidavit)
- Dr. John Fetchero — Practice: Otolaryngology. Stopped treating head & neck cases, and stopped seeing high-risk patients. (Florida Medical Association affidavit)
- Dr. E. Rawson Griffin — Practice: Family Practice. Stopped delivering babies, no longer performs vasectomies, and does not assist in surgery. (Florida Medical Association affidavit)
- Dr. Marc Blasser — Practice: Urology. Has restricted major procedures—primarily cancer cases. (Florida Medical Association affidavit)
- Dr. Carlos Esquivia-Munoz — Practice: General Orthopedics. Stopped seeing certain types of patients and performing high-risk procedures due to increased premium/litigation. (Florida Medical Association affidavit)
- Dr. William H. Jacobs — Practice: Urgent Care/Emergency Medicine. Stopped working on Saturday. Couldn't afford insurance for relieving physician. (Florida Medical Association affidavit)

Columbia County

- Shands at Lake Shore, which is the only hospital in a five-county area doing deliveries, lost one of two obstetricians. Program is at risk. (Shands at Lake Shore, July 2003 FHA survey)
- Dr. Pastor Rios — Practice: OB/GYN. Only practicing obstetrics. (Florida Medical Association affidavit)
- Dr. TM Vasko — Practice: General Surgery. Changed local hospital staff category from active to courtesy (with no ER call requirements). Stopped doing high-risk general surgical and emergency type procedures. (Florida Medical Association affidavit)

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- Dr. Luis Figueroa — Practice: Neurology. Stopped outpatient practice. (Florida Medical Association affidavit)
- Dr. Umesh Mhatre — Practice: Psychiatry. Avoids seeing suicidal and severely depressed patients. (Florida Medical Association affidavit)

Duval County

- More than 100 Jacksonville physicians temporarily suspended or totally stopped performing procedures. (*Associated Press*, May 6, 2003)
- North Florida Surgeons, the largest group of general surgeons in Jacksonville, stopped performing surgery. The group serves more than 20,000 patients and represents nearly one-third of the surgeons on call at the local hospital. The group has since resumed practice with a temporary insurance fix. Three of the physicians have found or plan to find work in other areas where insurance is more affordable. (*Jacksonville Business Journal*, July 7, 2003)
- The last remaining pediatric neurosurgeon at Wolfson Children's Clinic and on the First Coast was leaving for a job in Texas. (*Florida Times-Union*, May 2, 2003)
- North Florida Obstetrical & Gynecological Associates' 45 specialists stopped non-emergency gynecological procedures. (*Florida Times-Union*, May 2, 2003)
- General Surgery group halted all but follow-up care. The Group is back seeing patients in office and scheduling surgery. They physicians have faith the Legislature will enact comprehensive reforms. If not, they will have further decisions to make. (*Florida Times-Union*, April 23, 2003)
- St. Vincent's Medical Center was suspending mammography-screening services. (*Florida Times-Union*, May 1, 2003)
- Cardiothoracic and Vascular Surgical Associates was providing only follow-up care and emergency services. (*Florida Times-Union*, May 2, 2003)
- Jacksonville Orthopedic Institute stopped all care except for office visits. (*Florida Times-Union*, May 2, 2003)
- The Duval Health Department formed the Emergency Operating Center (EOC) to coordinate patient transfers through the Jacksonville MSA due to the physician shortages. More 200 people had to use the system because specialties were not readily available to ER patients or inpatients for consults. (*Florida Times-Union*, June 15, 2003)
- Three OB/GYN's in the Jacksonville Beaches area discontinued their obstetrics practice. (Baptist Medical Center Beaches, July 2003 FHA survey)
- Dr. Nak Y. Paek has practice general surgery in Jacksonville for 22 years. After his insurance company pulled out of Florida, Dr. Paek faced a 300 percent increase from another carrier. Faced with losing his hospital privileges, his only option is to try general practice. (Dr. Nak Y. Paek, January 2003 academic task force)

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- Dr. Kathryn Pearson is a breast-imaging radiologist from Jacksonville. She believes she may end up eliminating screen mammography for her 40-person radiology group if additional radiologists refuse to read mammography and/or insurance companies refuse to cover mammography. (Dr. Kathryn Pearson, January 2003 academic task force)
- Dr. Paul Shirley, who has practiced for 26 years, has had to limit his Jacksonville practice to knee arthroscopy, a low-risk area of medicine, due to insurance issues. He is interviewing for positions in other states. (Dr. Paul Shirley, January 2003 academic task force report)
- Dr. David Johnston, general surgeon and Chief of the Department of Surgery at St. Vincent's Medical in Jacksonville, and his group have elected to cease performing high-risk surgery such as pancreatic surgery and might be forced to discontinue performing all breast surgery. (Dr. David P. Johnston, Jr., January 2003 academic task force report)
- Dr. Gary Bowers, was the only surgeon in North Florida whom offered limb perfusions for melanoma patients. Because of the current malpractice climate, he no longer offers the high-risk procedure that treats select patients with extremity disease. (Dr. Gary J. Bowers, January 2003 academic task force report)
- Dr. Mark Abramson — Practice: Urology. Stopped seeing walk-in and Medicaid patients, and is no longer performing cystectomies. (Florida Medical Association affidavit)
- Dr. Richard Beck — Practice: Otolaryngology. Stopped performing high-risk surgical procedures, and has limited all ER on-call responsibility. (Florida Medical Association affidavit)
- Dr. Sudha Bogineni-Misra — Practice: Interventional Mammography. Breast procedures have been stopped or limited. (Florida Medical Association affidavit)
- Dr. Craig Cantor — Practice: OB/GYN. Resigned from two other hospitals and can only perform certain surgical procedures. (Florida Medical Association affidavit)
- Dr. Amit Chakrauarty — Practice: Pulmonary/Critical Care. Stopped seeing pregnant women. (Florida Medical Association affidavit)
- Dr. Paul Chappano — Practice: General Surgery. Stopped performing liver, pancreatic, trauma, and high-risk patient surgeries. (Florida Medical Association affidavit)
- Dr. George Chisholm — Practice: General Surgery. Stopped performing trauma/high-risk elective surgeries. (Florida Medical Association affidavit)
- Dr. Octavio Cosme — Practice: Interventional Cardiology. Considering stopping certain high-risk procedures. (Florida Medical Association affidavit)
- Dr. James DeOrio — Practice: Orthopedics. Has had to order more tests for fear that something might be overlooked/uneconomical. (Florida Medical Association affidavit)

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- Dr. Michael Drucker — Practice: Family Practice. No longer admitting patients to hospitals, ordering more tests, or referring patients to specialists. (Florida Medical Association affidavit)
- Dr. Paul Dundore — Practice: Pathologist. Dependent on surgeons. When they don't work, he doesn't work. (Florida Medical Association affidavit)
- Dr. Laurence Dunn — Practice: Radiology. Reduced number of mammograms performed; reduced high-risk intervention procedures. (Florida Medical Association affidavit)
- St. Vincent's Health System — Seven doctors have resigned due to malpractice issues. 18 doctors on leave due to insufficient malpractice coverage. Emergency Dept. has no call for plastic surgery, dermatology & rheumatology. Emergency Dept. has limited call for ears/nose & throat & general surgery. General surgeons have limited their involvement in high-risk surgery, especially breast surgery & trauma. (Florida Hospital Association affidavit)
- Dr. Robert Ellison Jr. — Practice: Vascular Surgery. Stopped performing general surgeries and risky vascular procedures, and is limiting the number of patients seen. (Florida Medical Association affidavit)
- Dr. Alicia Campbell — Practice: Internal Medicine. Has not been able to admit certain patients, and has had to refer them elsewhere. (Florida Medical Association affidavit)
- Dr. Jospeh Fares — Practice: Otolaryngology. Stopped performing extensive head and neck surgeries and no longer performs reconstructive surgeries. (Florida Medical Association affidavit)
- Dr. Theodore Felger — Practice: General & Vascular. Stopped performing carotid endarterectomies, exploratory laparotomies, and venous sclerotherapy. (Florida Medical Association affidavit)
- Dr. Cynthia Flanders — Practice: OB/GYN. No longer performs surgical procedures, and cannot afford to deliver babies at the volume she would like. (Florida Medical Association affidavit)
- Dr. Mark Freeman — Practice: Diagnostic Radiology. Limits performing mammograms, and looking into licensure in other states. (Florida Medical Association affidavit)
- Dr. Philip Gaillard — Practice: Family Practice. Stopped seeing hospitalized, nursing home, and high-risk patients. (Florida Medical Association affidavit)
- Dr. Jorge Gamba — Practice: Interventional Radiology. Certain procedures have not been performed due to shortage of surgeons to handle complications. (Florida Medical Association affidavit)

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- Dr. Douglas Gesner — Practice: Interventional Radiology. Certain procedures have not been performed due to shortage of surgeons to handle complications. (Florida Medical Association affidavit)
- Dr. Philip Glencross — Practice: Occupational Medicine. No longer performs spinal interventions, and will not treat children with certain conditions. (Florida Medical Association affidavit)
- Dr. Nelson Goldman — Practice: Otolaryngology. Quit private practice. (Florida Medical Association affidavit)
- Dr. Jeffrey Goldstein — Practice: Pathologist. Reduced breast cancer examinations due to unavailability of surgical specialists. (Florida Medical Association affidavit)
- Dr. Stephen Gyland — Practice: Pediatrics. Retired from private practice and works as medical director of a home health care facility. (Florida Medical Association affidavit)
- Dr. Philip Henkin — Practice: Neurosurgery. Stopped performing high-risk procedures, and transfers such patients to Shands. (Florida Medical Association affidavit)
- Dr. Mark Hofmann — Practice: Physical Medical/Rehab. No longer seeing hospital patients. (Florida Medical Association affidavit)
- Dr. Fredrick Holland — Practice: Pathologist. Curtailed surgical procedures; diminished volume of referred lab specimens. (Florida Medical Association affidavit)
- Dr. Peter Jansen — Practice: Family Practice. Considering moving. Stopped practicing obstetrics, and stopped hospital and nursing home work. (Florida Medical Association affidavit)
- Dr. David Johnston — Practice: General Surgery. Stopped performing trauma, pediatric, and elective surgeries, and has limited performing breast surgeries. (Florida Medical Association affidavit)
- Dr. Nina Kazerooni — Practice: Interventional Radiology. Certain procedures weren't performed due to shortage of surgeons. (Florida Medical Association affidavit)
- Dr. Ronald Kirsner — Practice: Psychiatry. Resigned privileges at all hospitals and practices only outpatient psychiatry. (Florida Medical Association affidavit)
- Dr. Craig Kobrin — Practice: Interventional Radiology. Certain procedures have not been performed due to a shortage of surgeons. (Florida Medical Association affidavit)
- Dr. Michael Koren — Practice: Cardiology. Has had 3 malpractice carriers in the past 3 years. (Florida Medical Association affidavit)

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- Dr. Kathleen Lee — Practice: Interventional Mammography. Interventional breast procedures have either been stopped or limited due to a surgeon shortage. (Florida Medical Association affidavit)
- Dr. Richard Laucks — Practice: Otolaryngology. Stopped accepting high-risk head and neck cancer patients, and will stop performing high-risk cancer surgeries. (Florida Medical Association affidavit)
- Dr. John Lovejoy — Practice: Orthopedic Surgery. Will retire if there is no meaningful tort reform. (Florida Medical Association affidavit)
- Dr. Bruce Maddern — Practice: Pediatric Otelorynology. Stopped performing neonatal high-risk surgery. (Florida Medical Association affidavit)
- Dr. Dennis McCarthy — Practice: Anesthesiology. Malpractice insurer has reduced coverage. (Florida Medical Association affidavit)
- Dr. George Miquel — Practice: Urology. Eliminated ER coverage. (Florida Medical Association affidavit)
- Dr. Mark Monroe — Practice: Anesthesia. Turns down certain high-risk patients. (Florida Medical Association affidavit)
- Dr. Kurt Mori — Practice: Interventional radiology. Certain procedures were not performed due to a shortage of surgeons. (Florida Medical Association affidavit)
- Dr. Robert Moore — Practice: Colon/rectal surgery. Stopped performing high-risk colon resectorsand sphincter repairs. (Florida Medical Association affidavit)
- Dr. Paul Oberdorfer — Practice: Gynecology. Will close practice in Dec. 2003. (Florida Medical Association affidavit)
- Dr. Sabina O'Laughlin — Practice: Pathology. As surgeons restrict their services so does she. (Florida Medical Association affidavit)
- Dr. Ben Olliff — Practice: Cardiology. Malpractice rates have tripled. (Florida Medical Association affidavit)
- Baptist Health — Sole remaining pediatric neurosurgeon ceased practice here. 27 physicians left the Baptist Health Medical Staff citing liability insurance concerns as cause. 3 physicians retired because of crisis. Difficulty recruiting. A 3-physician OB group ceased practicing obstetrics b/c of crisis. Only neurologist at Baptist Medical Center Nassau left the state due to crisis. (Florida Hospital Association affidavit)
- Dr. Prasanna Prabhu — Practice: Interventional Mammography. Interventional breast procedures have been either stopped or limited. (Florida Medical Association affidavit)
- Dr. Morteza Yavari — Practice: Urology. Self-insured and can not practice at St. Vincent, Baptist, St. Lukes and Beaches Hospitals because they do not accept self-insurance. (Florida Medical Association affidavit)

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- Dr. David Weiss — Practice: Pediatrics. No longer attending to patients in ER. No longer admitting patients to the hospital and is using a hospitalist through the University of Florida. Significantly limiting phone advice to parents of sick children. Either asking them to come to office or sending the children to ER after hours. (Florida Medical Association affidavit)
- Dr. Jeffrey Weitzner — Practice: Internal Medicine. Screens new patients more carefully. Concerned about ability to practice in skilled nursing facility. Decreased choice of consultants in Jacksonville (MDs have left the city recently). (Florida Medical Association affidavit)
- Dr. Kenneth Williams — Practice: General Surgery. Is unable to perform certain surgeries that are an area of significant need from a patient care standpoint. Personally knows of five surgeons actively seeking to leave the state. One of which is leaving by 7/30/03. (Florida Medical Association affidavit)
- Dr. Daniel Wygan — Practice: Pulmonary/Crit Care. Has had to alter surgical referral patterns due to availability and quality—physicians are leaving the state. (Florida Medical Association affidavit)
- Dr. Anthony Toledo — Practice: Diagnostic Radiology. Has limited number of mammograms, and interventional procedures due to a lack of surgical backup. (Florida Medical Association affidavit)
- Dr. Stephen Tunstill — Practice: Anesthesiology. Wife's physician, Dr. Julian Allen, has done a breast biopsy on her and took great care of her. Now he no longer cares for patients with breast problems because of the liability environment. (Florida Medical Association affidavit)
- Dr. Frank Sanchez — Practice: Interventional Radiology. Certain interventional procedures have not been performed due to a shortage of surgeons to handle possible complications. (Florida Medical Association affidavit)
- Dr. Roy Schnanss — Practice: Opthamalology. Will not do any complicated cases by himself. Will not do any more charity cases unless he gets malpractice relief. (Florida Medical Association affidavit)
- Dr. John Scott — Practice: Anesthesiology. Has altered practice to more conservative and defensive approach, ordering labs that he would not otherwise have considered necessary and canceling procedures that otherwise could have been performed without more extensive evaluation. (Florida Medical Association affidavit)
- Dr. Steve Shirley — Practice: Radiology. Certain interventional procedures have not performed due to a shortage of surgeons to handle possible complications. (Florida Medical Association affidavit)
- Dr. Jamie Surratt — Practice: Interventional Mammography. Interventional breast procedures have either been stopped or limited due to a shortage of surgeons to handle possible complications. (Florida Medical Association affidavit)

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- Dr. Charles Adams, Jr. — Practice: Ophthalmology. Is a corneal specialist, and has stopped seeing high-risk corneal transplant patients. (Florida Medical Association affidavit)
- Dr. Timothy Daniel — Practice: Interventional Radiology. Certain procedures have not been performed due to a shortage of surgeons. (Florida Medical Association affidavit)
- Dr. Gary Bowers — Practice: Gen.Surg/Surg Oncology. Stopped a measure for treating melanoma patients. Can no longer assume risks. (Florida Medical Association affidavit)
- Dr. Jeffrey E. Brink — Practice: Otolaryngology. No more complicated cases with increased chance of failure, lack of improvement or injury. (Florida Medical Association affidavit)
- Dr. Robert E. Duncan — Practice: Plastic/Reconstructive Surgery. Stopped head & neck cancer reconstruction, and breast & severe deformity reconstruction. (Florida Medical Association affidavit)
- Dr. Lawrence Gnage — Practice: Orthopedic Surgery. Stopped back and hand calls and all revision surgery. Considering moving to N.C. (Florida Medical Association affidavit)
- Dr. Robert Gruber — Practice: Interventional Pain. Restricted use of spinal injections. (Florida Medical Association affidavit)
- Dr. Beverly Mcmillin — Practice: Pediatric ENT. Has had to dramatically decrease liability coverage, and will limit exposure to high-risk patients. (Florida Medical Association affidavit)
- Dr. Alicia Campbell — Practice: Internal Medicine. Not able to admit certain cases/has to refer them elsewhere. (Florida Medical Association affidavit)
- Dr. Salvatore Diloreto — Practice: Cardiology. Has become much more conservative in performing interventional procedures. (Florida Medical Association affidavit)
- Shands Jacksonville Medical Center, Inc. — Hospital Emergency Incident Command System activated due to crisis May 1, through May 19, 2003. During that period, 75 consult requests processed by special-ties. 13 patients admitted to urgent or emergency surgery. Patients referred from at least 5 different hospitals/medical centers. (Florida Hospital Association affidavit)
- Dr. Manley W. Kilgore, II — Practice: Neurology. Stopped doing cerebral afteriograms. (Florida Medical Association affidavit)
- Dr. Leonardo Jr. Nasca — Practice: Emergency Medicine. As tertiary care center physician, has increased patients referred. (Florida Medical Association affidavit)

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- Dr. James G.T. Nealis — Practice: Child Neurology. Will not see babies; retired but returned; seeking now to leave state. (Florida Medical Association affidavit)
- Dr. Gregory Sengstock — Practice: Neurology. Minimized charitable patients; low/no pay patients; stopped ordering tests (angiograms). (Florida Medical Association affidavit)
- Dr. Kevin L. Winslow — Practice: Reproductive Endocrinology. Stopped surgeries on high-risk individuals. (Florida Medical Association affidavit)
- Brooks Rehabilitation Hospital — Only pediatric neurosurgeon left state. Difficult to attract another pediatric neurosurgeon. If a patient has cardiac or respiratory arrest, staff must call 911 and rely on Rescue Unit. In the past, Brooks could utilize services of intensive care physicians and adjunct services from an adjacent acute care hospital. Discontinued at direction of physician's insurance company, even though Brooks has favorable claims experience &, as a rehab hospital, does not have physicians available on a 24-hr basis. (Florida Hospital Association affidavit)
- Dr. Charles F. Yeagle — Practice: General Surgery. Hasn't practiced in FL in last 2 1/2 months. Left state & has been doing locem tenens. (Florida Medical Association affidavit)
- Dr. Arnold A. Zeal — Practice: Neurosurgery. Stopped doing pediatric cases; limited certain other cases; refers cases out. (Florida Medical Association affidavit)
- Dr. John Baker — Practice: Internal Medicine/Geriatrics. Moving 9-15-03. (Florida Medical Association affidavit)
- Dr. Clarence Boudreaux — Practice: Dermatology. Hired a doctor who could not obtain malpractice insurance, so had to let him go. (Florida Medical Association affidavit)
- Dr. Samuel Brown — Practice: Reproductive Endocrinology. Decreased surgeries due to limitation of general surgeon back-up in our region. (Florida Medical Association affidavit)
- Dr. David Csikai — Practice: Plastic Surgery. Stopped taking certain reconstructive procedures. (Florida Medical Association affidavit)
- Dr. Rajesh M. Patel — Practice: Internal Medicine. Stopped ER calls, and does not see patients with chronic pain on significant pain pills or tranquilizers. (Florida Medical Association affidavit)
- Dr. Leonando Alonso — Practice: Emergency Medicine. No hand surgeons or cardiovascular call for six weeks this year; limited surgeon coverage requiring transfer to distant facilities. Specialties affected: Cardiology, Cardiovascular Surgery, Gastroenterology, General Surgery, Hand Surgery, Neurosurgery, Oral/Maxillo-Facial Surgery, Orthopedics, Pediatrics/Pediatric Surgery, Plastic Surgery, Thoracic Surgery, Vascular Surgery. (Florida Medical Association affidavit)

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- Dr. Kenneth Aung-Din — Practice: Emergency Medicine. Several doctors have retired due to crisis. Specialties affected: Cardiology, Cardiovascular Surgery, General Surgery, Gynecology, Hand Surgery, Neurosurgery, Oral/Maxillo-Facial Surgery, Orthopedics, Pediatrics/Pediatric Surgery, Plastic Surgery, Thoracic Surgery, Vascular Surgery. (Florida Medical Association affidavit)
- Dr. Steven Blake — Practice: Emergency Medicine. Surgeons have taken leaves of absence due to crisis; lack of patient care; on call specialists are difficult to find causing transfer of patients distances of 100 miles. Specialties affected: Cardiology, Cardiovascular Surgery, General Surgery, Gynecology, Hand Surgery, Neurosurgery, Oral/Maxillo-Facial Surgery, Orthopedics, Pediatrics/Pediatric Surgery, Plastic Surgery, Thoracic Surgery, Vascular Surgery. (Florida Medical Association affidavit)
- Dr. Thomas Bozzato — Practice: Emergency Medicine. Transfers needed due to lack of on-call specialists; increased ER volume due to unavailability of appointments in specialists' offices. Specialties affected: Cardiology, Cardiovascular Surgery, General Surgery, Gynecology, Hand Surgery, Neurosurgery, Obstetrics, Oral/Maxillo-Facial Surgery, Orthopedics, Otolaryngology, Pediatrics/Pediatric Surgery, Plastic Surgery, Thoracic Surgery, Urology, Vascular Surgery. (Florida Medical Association affidavit)
- Dr. Matthew Bruckel — Practice: Emergency Medicine. No general surgery call 94% of days per month; general surgery patients require transfer up to 1 hour away. Specialties affected: General Surgery, Hand Surgery. (Florida Medical Association affidavit)
- Dr. Lynn Cosentino — Practice: Emergency Medicine. Lack of specialists results in long waits, bad outcomes, and angry families. Specialties affected: Burns, General Surgery, Gynecology, Hand Surgery, Neurosurgery, Oral/Maxillo-Facial Surgery, Radiology. (Florida Medical Association affidavit)
- Dr. Doreen Dargon — Practice: Emergency Medicine. Lack of specialists. Specialties affected: Burns, Cardiovascular Surgery, General Surgery, Hand Surgery, Neurosurgery, Obstetrics, Ophthalmology, Orthopedics, Pediatrics/Pediatric Surgery, Plastic Surgery, Thoracic Surgery, Urology, Vascular Surgery. (Florida Medical Association affidavit)
- Dr. Jay Edelberg — Practice: Emergency Medicine. Sub-specialists are retiring or reducing ER availability. Specialties affected: General Surgery, Neurosurgery, Oral/Maxillo-Facial Surgery, Otolaryngology, Pediatrics/Pediatric Surgery, Plastic Surgery, Thoracic Surgery, Urology, Vascular Surgery. (Florida Medical Association affidavit)
- Dr. Mark Horton — Practice: Emergency Medicine. In the past few months, we had to transfer 10 critical patients by helicopter to Gainesville for pediatric neurosurgical care because we have no pediatric neurosurgeon in our tertiary care center, because of the malpractice insurance issues. This resulted in serious medical risk to these patients and additional great expenses. Specialty affected: Neurosurgery. (Florida Medical Association affidavit)

- Dr. James Lovett — Practice: Emergency Medicine. It is difficult getting orthopedic, hand and general surgical ER consults. Specialties affected: Cardiology, Cardiovascular Surgery, Gastroenterology, General Surgery, Gynecology, Hand Surgery, Orthopedics, Thoracic Surgery, Vascular Surgery. (Florida Medical Association affidavit)

- Dr. Suman Mayer — Practice: Emergency Medicine. Critical neurosurgical patients have been transferred to other hospitals. Specialties affected: Neurosurgery, Oral/Maxillo-Facial Surgery. (Florida Medical Association affidavit)

- Dr. David Murray — Practice: Emergency Medicine. ER patients have had limited access to all surgical specialties as a direct result of the cost/availability of liability insurance. Specialties affected: Burns, Cardiovascular Surgery, General Surgery, Gynecology, Hand Surgery, Orthopedics, Radiology, Thoracic Surgery, Vascular Surgery. (Florida Medical Association affidavit)

- Dr. Radames Oliver — Practice: Emergency Medicine. Emergency medicine care can be delayed due to lengthy transfers. No pediatric neurosurgery in town. The current malpractice crisis has made specialties unavailable to many patients, forcing us to transfer patients, sometimes hundreds of miles away in order to receive the care they need. Many specialists are leaving town because they cannot afford malpractice coverage. Some cannot obtain coverage in their specialties as costs are prohibitive. The transferring of patients distracts emergency physicians from providing care to other patients we have and places them in jeopardy because of this. Specialties affected: Burns, Cardiovascular Surgery, Emergency Medicine, General Surgery, Gynecology, Hand Surgery, Neurosurgery, Obstetrics, Oral/Maxillo-Facial Surgery, Orthopedics, Otolaryngology, Plastic Surgery, Thoracic Surgery, Urology, Vascular Surgery. (Florida Medical Association affidavit)

- Dr. Maryann Pasher — Practice: Emergency Medicine. Patients had to be transferred, care was prolonged, and the system was slowed greatly because of the time required to transfer the patients. This also takes from the ability to care for other ER patients in the hospital at the same time. Specialties affected: Cardiovascular Surgery, General Surgery, Gynecology, Obstetrics, Orthopedics, Thoracic Surgery, Vascular Surgery. (Florida Medical Association affidavit)

- Dr. Rajnikanta Patel — Practice: Emergency Medicine. It is very difficult to get neurosurgeons, especially if the patient is under 18 years of age. All pediatric patients with neurosurgical needs have to be transferred by Life Flight to Gainesville. Specialties affected: General Surgery, Neurosurgery. (Florida Medical Association affidavit)

- Dr. J.R. Perez-Poveda — Practice: Emergency Medicine. General surgeons refuse to take trauma patients; certain specialists refuse to take ER call. Specialties affected: Cardiovascular Surgery, Emergency Medicine, General Surgery, Hand Surgery, Neurosurgery, Ophthalmology, Oral/Maxillo-Facial Surgery, Orthopedics, Otolaryngology, Trauma Care Center, Thoracic Surgery, Vascular Surgery. (Florida Medical Association affidavit)

- Dr. Matthew Rill — Practice: Emergency Medicine. Many people cannot have heart catheterization due to lack of cardiothoracic back up. This puts these patients at unnecessary risk. Young pregnant women are presenting for delivery in the ER due

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to the decreased number of OB/GYNs. Hand injuries need to be transferred from a Level I trauma center to hospitals several counties away. If reattachment was possible, this delay in care may prevent attempts at doing so due to the time involved in the transfer. Similar problems occur in general surgery, cardiac surgery, and OB/GYN. Specialists are reluctant to take call for ED. This creates additional risks to patients due to delays in care, while we, the emergency physicians, attempt to find appropriate care, often involving transfer to other facilities. Specialties affected: Burns, Cardiovascular Surgery, General Surgery, Gynecology, Hand Surgery, Neurosurgery, Obstetrics, Orthopedics, Pediatrics/Pediatric Surgery, Plastic Surgery, Trauma Care Center, Thoracic Surgery, Urology, Vascular Surgery. (Florida Medical Association affidavit)

- Dr. Andrew Saver — Practice: Emergency Medicine. We have had to transfer patients from Jacksonville to Gainesville on repeated occasions due to lack of pediatric neurosurgical coverage. Specialty affected: Neurosurgery. (Florida Medical Association affidavit)

- Dr. Jeffrey Smowton — Practice: Emergency Medicine. Lack of specialists. Specialties affected: Cardiovascular Surgery, Emergency Medicine, General Surgery, Hand Surgery, Neurosurgery. (Florida Medical Association affidavit)

- Dr. Theodore Szymanski — Practice: Emergency Medicine. Access to general surgeons was extremely limited for patients in our region. We were made to transfer patients to different facilities around the county in order for the patients to receive proper care. Specialty affected: Emergency Medicine. (Florida Medical Association affidavit)

- Dr. Robert Thomas — Practice: Emergency Medicine. Call coverage being decreased, physicians retiring early, difficult getting specialists. Specialties affected: Cardiology, Cardiovascular Surgery, General Surgery, Gynecology, Hand Surgery, Neurosurgery, Oral/Maxillo-Facial Surgery, Orthopedics, Pediatrics/Pediatric Surgery, Plastic Surgery, Thoracic Surgery, Vascular Surgery. (Florida Medical Association affidavit)

- Dr. George Woodward — Practice: Emergency Medicine. The current crisis has limited the availability of the general surgeon, which in turn has a chain reaction on nearly all other specialties, since the general surgeon is everyone's back-up. Specialties affected: Cardiovascular Surgery, Emergency Medicine, Gastroenterology, General Surgery, Gynecology, Hand Surgery, Neurosurgery, Orthopedics, Plastic Surgery, Radiology, Thoracic Surgery, Vascular Surgery. (Florida Medical Association affidavit)

Escambia County

- Hospitals were reporting problems recruiting physicians because of discrepancies in the cost of premiums in neighboring states. It costs a physician three times more in liability premiums to practice in Escambia County, Florida, than it does to practice in Baldwin County, Alabama — less than 25 minutes drive from downtown Pensacola. (Baptist Health Care, July 2003 FHA survey)

- Dr. John Axley — Practice: Neurology. Must reduce patient encounters due to increasing cost of insurance. (Florida Medical Association affidavit)

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- Dr. Phillip Benton — Practice: Orthopedic Surgery. Discontinued treatment of Medicare, HMO and Medicaid patients, and moved to another state. (Florida Medical Association affidavit)

- Dr. Juliet DeCampos — Practice: Orthopedic Surgery. Has limited trauma calls. No longer treats pelvic fractures, and has stopped performing hand and spine surgeries and hip replacements. (Florida Medical Association affidavit)

- Dr. Cheryl Jones — Practice: Dermatology. Refuses to give sulfamethixazole even when patients request it due to rare side effects. (Florida Medical Association affidavit)

- Dr. William Jones — Practice: Radiology. Moved practice to Foley, AL. (Florida Medical Association affidavit)

- Dr. Richard Ziemba — Practice: Internal Medicine. Retired at age 66 due to increasing liability insurance costs. Desired PT nursing home medicine but carrier will not write NH insurance. (Florida Medical Association affidavit)

- Dr. Douglas Tappan — Practice: Orthopedic Surgery. No longer performs total joint arthroplasties (stopped these in 2002). Gave up free cerebral palsy clinic for children in Pensacola because of liability concerns and because the cost of liability insurance made him spend this time seeing paying patients. (Florida Medical Association affidavit)

- Dr. Kirby Turnagg — Practice: Orthopedic Surgery. Severely limiting Medicaid patients, offering higher-risk procedures in general, turning away more and more complex workers compensation patients for fear of being sued and the reality that he must make more money to pay my malpractice. (Florida Medical Association affidavit)

- Dr. William Smith — Practice: Orthopedic Surgery. Limiting Medicare patient access. Reimbursement is too low for high cost of insurance. No Medicaid. Limiting scope of spine surgery practice. Moving more of his practice to Atmore AL. (Florida Medical Association affidavit)

- Dr. George Haedicke — Practice: Plastic Surgery/Trauma. Qu[illegible]etic surgery, stopped seeing high-risk patients, and dropped hospitals ER c[illegible] (Florida Medical Association affidavit)

- Dr. Leslie Hagan — Practice: Family Practice. Stopped pract[illegible]ail medicine on private patients, and dropped all charity work. (Florida Medical Association affidavit)

- Dr. Barry Lurate — Practice: Orthopedic Surgery. Severely restricted Medicaid patients, avoids seeing high-risk orthopedic patients. (Florida Medical Association affidavit)

- Dr. Robert Pyle — Practice: General/Thoracic/Vascular Surgery. No more trauma/ER patients and has stopped doing high-risk surgeries. (Florida M[illegible]al Association affidavit)

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Flagler County

- Radiology Associates, a group of Radiologists that runs a large outpatient imaging center in the community, announced the potential for discontinuing mammography in August if the crisis is not averted. This is the same group impacting Volusia County and Halifax Medical Center, but if they pull out, Flagler County will be significantly impacted. (Florida Hospital - Flagler, July 2003 FHA survey)

- Florida Hospital - Flagler is currently trying to recruit a much needed OB/GYN physician to the community and have been unable to do so thus far because of the significantly high rates being quoted to incoming physicians. The hospital had to create an employment model with a self-insured offering to even be competitive with out of state opportunities. (Florida Hospital - Flagler, July 2003 FHA survey)

- St. Augustine's Flagler Hospital lost four general surgeons and may lose the city's only neurosurgeon. (*Jacksonville Business Journal*, February 10, 2003)

- Dr. John M. Russell — Practice: Orthopedic Surgery. Has not yet changed practice significantly but will. (Florida Medical Association affidavit)

Franklin County

- At George E. Weems Memorial Hospital in Apalachicola, there is only one full-time emergency room physician available to treat all of the region's emergency and trauma cases. (George E. Weems Memorial Hospital, March 2003 FHA survey)

- Dr. David Pierce — Practice: Emergency Medicine. Medical director of ED of Weems Hospital/Apalachicola—one of the most rural hospitals in the state (farthest from any medical center). Due to high risk of practicing emergency medicine in this rural setting, was unable to get traditional insurance, in spite of no claims history. Had to insure through JUA. Cost of insurance works out to approximately $50/patient visit—while state reimburses an average of $28 for each Medicaid patient I see. Most patients here (35-40%) pay nothing. I was working up to 600 hours/month as my initial plan of taking in partners (also boarded in EM) was eliminated as no physicians were interested in this practice given the current climate. I had no inquiries from out of state, in spite of national advertising. Specialty follow-up care/transfer is always a problem for a rural hospital. In this region of fishermen and oystermen, hand surgery is a major issue and good care is vital to these workers. These patients often have less than ideal outcomes, as physicians are no longer willing to treat them. Specialties affected: General Surgery, Hand Surgery, Internal Medicine, Neurology, Orthopedics, Plastic Surgery. (Florida Medical Association affidavit)

Hamilton County

- One family practice physician closed his private practice because he could not afford the malpractice coverage. This was already a medically undeserved area. (Shands HealthCare, July 2003 FHA survey)

Jackson County

- Dr. Nikorn Arunakul — Practice: General Practice. Major surgeries are no longer performed. No ER PT visits. (Florida Medical Association affidavit)

- Dr. Richard Christopher Jr. — Practice: Internal Medicine. Stopped seeing nursing home patients and avoids all ER calls. (Florida Medical Association affidavit)

- Dr. Seymour Rosen — Practice: Ophthalmology. Stopped performing lasik eye surgeries. (Florida Medical Association affidavit)
- Dr. Richard G. Brunner — Practice: General Surgery/Critical Care. Stopped critical care except for patients. (Florida Medical Association affidavit)
- Dr. David Jaslouski — Practice: Urology. Closed Central Florida's only kidney transplant program. (Florida Medical Association affidavit)

Leon County

- Tallahassee Memorial Hospital eliminated its mammography services. (Tallahassee Memorial Hospital, January 2003 FHA survey)
- The seven physicians and four midwives at North Florida Women's Care, who deliver more than 60 percent of the babies born at Tallahassee Memorial Hospital, will stop delivering babies in 2004. (*Tallahassee Democrat*, May 13, 2003)
- Tallahassee Orthopedic Clinic was forced to limit services. (*Tallahassee Democrat*, May 13, 2003)
- Dr. Jana Bures-Forsthoefel, an established OB/Gyn in Tallahassee (practiced 20 years) will be forced to close her practice October 1. She delivers 65-85 babies a month. Her carrier is leaving the state and tail coverage has been quoted as $439,000 due Oct. 1. No carrier has yet been found to accept new clients. Florida underwriter insurance will provide $250,000 coverage at a cost of approx. $380,000 with no retro coverage. This leaves a potential cost of $800,000 by Oct for any coverage. (E-mail from Dr. Forstoefel to the FMA July 21, 2003; her story has also been told in the *Tallahassee Democrat*).
- Dr. Flora Danisi retired early due to the medical liability crisis. (Capital Medical Society, July 3, 2003)
- Drs. Mark Vogelhut, Bill Askins, Alan Klochany, Glenn Summers have left the state. (Capital Medical Society, July 3, 2003)
- Dr. Don Willis - perineonatologist has to close his private practice and become a hospital employee due to the medical liability crisis. (Capital Medical Society, July 3, 2003).
- Southern Urological is restricting high-risk practice. (Capital Medical Society, July 3, 2003).
- Dermatology and Associates is discontinuing ER coverage. (Capital Medical Society, July 3, 2003).
- Dr. Todd Crawford — Practice: Neurosurgery. Refers high-risk patients outside of area. (Florida Medical Association affidavit)
- Dr. Julian Hurt — Practice: Cardiovascular Surgery. Opened practice in Valdosta, GA. (Florida Medical Association affidavit)
- Dr. Karen Krueger — Practice: Internal Medicine. Stopped seeing Medicaid patients, and is seriously thinking of moving. (Florida Medical Association affidavit)

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- Dr. H. Hutson Messer — Practice: Gynecology. Stopped performing high-risk surgical procedures, and no longer accepts Medicaid patients. (Florida Medical Association affidavit)
- Dr. Charles Moore — Practice: Plastic Surgery. Stopped performing all breast reconstruction procedures. (Florida Medical Association affidavit)
- Dr. Charles Murrah — Practice: Cardiovascular Surgery. Moved to Valdosta. (Florida Medical Association affidavit)
- Dr. David Saint — Practice: Cardiovascular Surgery. Now having to drive to Valdosta GA to try to make enough money to pay medical malpractice. (Florida Medical Association affidavit)
- Dr. Robert Ashmore — Practice: OB/GYN. Refers out all high-risk OB patients. (Florida Medical Association affidavit)
- Dr. A.J. Brickler — Practice: OB/GYN. Refers out high-risk OB patients, and no longer sees GYN patients. (Florida Medical Association affidavit)
- Dr. Arthur Clements — Practice: OB/GYN. Refers out all high-risk OB patients. (Florida Medical Association affidavit)
- Dr. Armand Cognetta — Practice: Dermatology. Stopped seeing Medicaid patients. (Florida Medical Association affidavit)
- Dr. Peter Loeb — Practice: Orthopedic Surgery. Stopped revision surgery, pelvic surgery, and stopped ER cases. (Florida Medical Association affidavit)
- Dr. J.W. Loux — Practice: D.O. Nothing intensive, no surgeries, and no ESI's. (Florida Medical Association affidavit)
- Dr. Charles Maitland — Practice: Neurology. If there is no cap, will discontinue insurance. (Florida Medical Association affidavit)
- Dr. Andrea D. King — Practice: OB/GYN. Now refers all high-risk OB patients; no more surgery on GYN patients. (Florida Medical Association affidavit)
- Dr. Kenneth McAlpine — Practice: OB/GYN. Refers out all high-risk OB patients; no longer performs surgery on GYN patients. (Florida Medical Association affidavit)
- Dr. Alfredo Nova — Practice: OB/GYN. No high-risk OB patients; no more surgery on GYN patients. (Florida Medical Association affidavit)
- Dr. David R. O'Bryan — Practice: OB/GYN. Refers out all high-risk OB patients; no longer performs surgery on GYN patients. (Florida Medical Association affidavit)

Nassau County

- As of June 27, Nassau County lost three physicians, two primary care and one neurologist, to the pressures of high insurance premiums. This represents 10

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percent of the physicians who practice in the community. (Baptist Medical Center Nassau, July 2003 FHA survey)

- Dr. E. William McGrath — Practice: OB/GYN. Stopped high-risk obstetrics, and no longer performs gynecological surgeries on high-risk candidates. (Florida Medical Association affidavit)
- Dr. Diana Twiggs — Practice: Family Practice. Has decreased certain office procedures and failed to pursue expanding her scope of practice, such as not being able to add OB or GYN procedures. (Florida Medical Association affidavit)
- Dr. Donald Twiggs — Practice: Family Practice. Decreased office procedures. (Florida Medical Association affidavit)
- Dr. James T. Dawsey — Practice: OB/GYN. Retired 10 years early, and converted to limited license to volunteer for health department. (Florida Medical Association affidavit)
- Dr. E. William McGrath — Practice: OB/GYN. No more high-risk OB, and no more GYN surgeries on high-risk candidates. (Florida Medical Association affidavit)
- Dr. John Poser — Practice: Surgery. Stopped doing any high-risk reconstrucitve surgeries, and is considering retirement. (Florida Medical Association affidavit)

Okaloosa County

- Physicians from Orthopedic Associates, P. A., suspended low-cost physicals for public school athletes and will stop volunteering at school events. (*Northwest Daily News*, May 25, 2003)
- Dr. Gustavo Arriola — Practice: Neurosurgery. Suspended all hospital-based procedures, including surgery and consultations. (Florida Medical Association affidavit)
- Dr. Billy Buckelew — Practice: Family Practice. Stopped performing major surgeries, vasectomies, and other procedures in office. (Florida Medical Association affidavit)
- Dr. Mark Calkins — Practice: Orthopedics. No longer assists with high-risk spine procedures. (Florida Medical Association affidavit)
- Dr. Steven Clark — Practice: Plastic Surgery. Stopped performing reconstructive surgeries on high-risk patients. (Florida Medical Association affidavit)
- Dr. Steven Doheny — Practice: Psychiatry. No longer sees chronic pain patients, plans to stop ER/hospital work, and is considering moving. (Florida Medical Association affidavit)
- Dr. Leacis Hale — Practice: Ophthalmology. Stopped performing intraocular surgeries, and withdrew from on-call schedule. (Florida Medical Association affidavit)

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- Dr. Dale Johns — Practice: Neurosurgery. Will retire due to insurance crisis. (Florida Medical Association affidavit)
- Dr. A. Barnard Russell — Practice: Family Practice. Gave up OB, and gave up performing major and gynecological surgeries. (Florida Medical Association affidavit)
- Dr. Bruce Wilkind — Practice: Neurosurgery. Has stopped performing all high-risk procedures, such as brain surgery and head and spine trauma. (Florida Medical Association affidavit)
- Dr. Franklin Segal — Practice: Anesthesiology. Stopped doing pain medicine and post operative pain blocks. (Florida Medical Association affidavit)
- Dr. Peter Senechal — Practice: Family Practice. Forced to stop assisting in major surgeries and stopped performing in-office vasectomies. (Florida Medical Association affidavit)
- Dr. John Sites — Practice: Family Practice. Has been forced to stop assisting on major surgery procedures on own patients due to higher insurance rates. No longer performs vasectomies and other procedures in his office. (Florida Medical Association affidavit)
- Dr. Reynald Pouliot — Practice: OB/GYN. Stopped doing high-risk pregnancies, ER coverage, GYN services. (Florida Medical Association affidavit)

Putnam County

- Dr. Charles Bennett — Practice: Family Practice. Reduced ER coverage and Medicaid. (Florida Medical Association affidavit)

Santa Rosa County

- Dr. Peter Szymoniak — Practice: Orthopedics. Insurance cancelled. (Florida Medical Association affidavit)

St. John's County

- Dr. Jay Edelberg — Practice: Emergency Medicine. Must refer almost all neurosurgical cases and pediatric general surgical cases. (Florida Medical Association affidavit)
- Dr. Juan Larroude — Practice: OB/GYN. Stopped practicing obstetrics. (Florida Medical Association affidavit)
- Dr. Albert Volk — Practice: Orthopedic Surgery. Stopped seeing Medicaid patients, no longer treats pediatric elbow or high-risk fractures, trauma or joint revisions, and no longer performs in-office surgeries. (Florida Medical Association affidavit)
- Specialty coverage for emergency and/or trauma care has compromised the provision of emergency/trauma care in the following specialty areas: General Surgery, Neurosurgery, Oral/Maxillo Facial Surgery, Ophthalmology, Pediatrics/Pediatric Surgery, Plastic Surgery, Thoracic Surgery, Urology, Vascular Surgery. (Florida College of Emergency Physicians affidavit)

* This report was last updated on August 11, 2003

- Reporting emergency physician indicates that sub-specialists are retiring or reducing ER availability. (Florida College of Emergency Physicians affidavit)

- Dr. Gregory Smith — Practice: Facial Plastic Surgery. Stopped taking emergency room call for trauma, stopped doing major hospital procedures, and stopped performing certain office surgeries/procedures. (Florida Medical Association affidavit)

Taylor County

- Dr. Firas Hamdan — Practice: Otolaryngology. No longer takes on trauma or high-risk cases, and has limited to elective general. (Florida Medical Association affidavit)

Wester

THE FLORIDA SENATE

COMMITTEE ON JUDICIARY

Location
515 Knott Building

Mailing Address
404 South Monroe Street
Tallahassee, Florida 32399-1100
(850) 487-5198

J. Alex Villalobos, *Chair*
Dave Aronberg, *Vice Chair*

Dawn Roberts, *Staff Director*

Senate's Website: *www.flsenate.gov*

July 29, 2003

Gerald Wester
Capital City Consulting
119 East Park Ave.
Tallahassee, FL 32301

Dear Mr. Wester:

In reviewing the transcript of the Senate Committee on Judiciary meeting on July 14-15, 2003, we have identified certain issues for which it requests additional information. Specifically, we request a response in the following instance:

1. Please provide the names and affiliations of those board members of professional liability insurnace companies that you represent that are also officers, board members, or staff of Florida professional associations.

We ask that you please provide the appropriate responsive documentation to the Senate Committee on Judiciary no later than **5:00 pm on Monday, August 4, 2003.** To aid you in your response, we have attached those pages of the transcript that contain your testimony. If you have any questions, please contact Judiciary Committee staff at (850) 487-5198.

Sincerely,

Senator Alex Villalobos
Chair

JAMES E. "JIM" KING, JR.
President

ALEX DIAZ DE LA PORTILLA
President Pro Tempore

Aug 04 03 03:31p Capital City Consultants (850) 222-9073 p.1

CAPITALCITY
CONSULTING, L.L.C.

119 East Park Avenue
Tallahassee, Florida 32301
Tel: (850) 222-9075
Fax: (850) 222-9073

Fax Cover Sheet

To: Chairman Alex Villalobos Date: 8-4-03

Company: Senate Judiciary Committee

From: Gerald Wester

Telephone: 222-9075 Fax Number: 222-9073

Number of pages including Cover sheet: 2

Mr. Chairman,

Here is a letter in response to your July 29 inquiry. Please call with any additional questions.

Gerald

June 2003

Gerald C. Wester
Patricia G. O'Connell

Aug 04 03 03:32p Capital City Consultants (850) 222-9073 p.2

CAPITALCITY
CONSULTING, L.L.C.

119 East Park Ave.
Tallahassee, FL 32301
Tel: 850.222.9075 - Fax: 850.222.9073

August 4, 2003

The Honorable Alex Villalobos
Chairman, Senate Judiciary Committee
404 South Monroe Street
Tallahassee, Florida 32399-1100

Mr. Chairman,

This letter is in response to your letter dated July 29, 2003 inquiring whether GE Medical Protective Company, whom I represent, has board members that are also officers, board members, or staff of a Florida professional association. My client has informed me they do not have company board members that are also board members, officers, or staff of a Florida professional association.

If you need further information, please do not hesitate to contact me.

Sincerely,

Gerald Wester

Nicholas V. Iannuzzi
Ronald C. LaFace, Jr.

White

THE FLORIDA SENATE

COMMITTEE ON JUDICIARY

Location
515 Knott Building

Mailing Address
404 South Monroe Street
Tallahassee, Florida 32399-1100
(850) 487-5198

J. Alex Villalobos, *Chair*
Dave Aronberg, *Vice Chair*

Dawn Roberts, *Staff Director*

Senate's Website: *www.flsenate.gov*

July 29, 2003

Bob White
President, First Professionals Insurance Company
1000 Riverside Avenue
Ste. 800
Jacksonville, FL 32204

Dear Mr. White:

In reviewing the transcript of the Senate Committee on Judiciary meeting on July 14-15, 2003, we have identified several occurrences where you were asked to provide information subsequent to your testimony. Additionally, the committee has identified certain issues for which it requests additional information. Specifically, we request a response in the following instances:

1. Please provide the number of claims per 100 insured physicians for each year from 1996 through 2002.
2. Please provide the number of physicians insured by FPIC for each year from 1996 through 2002.
3. Please provide a copy of the contract or any other agreement between FPIC and the Florida Medical Association (FMA) regarding FPIC's payment of an endorsement fee to the FMA. If not so indicated in the contract, please indicate how long this endorsement relationship has been in existence. Please verify the total amount FPIC has paid the FMA for the period this agreement has been in effect.
4. Please indicate to which other state medical associations FPIC, FPIC's holding company, or FPIC's sister companies make payment of an endorsement fee. Please indicate the amount of such fees and the period that the agreement has been in effect.
5. Please provide a listing of FPIC's rate filings for the past five years, as reported to the Department of Insurance/Office of Insurance Regulation.
6. Please define the term "allocated loss expenses." Please indicate what allocated loss expenses were accrued from FPIC's Florida operations.
7. Please provide the details of how you discount certain physicians, including the criteria and the amounts of discounts. Include a detailed description of the "claims free" discount, i.e., how long does the physician need to remain claims free and what discount do they receive? Is the discount available in all specialties?
8. Does FPIC use experience rating? Or just the "claims free" discount?

JAMES E. "JIM" KING, JR.
President

ALEX DIAZ DE LA PORTILLA
President Pro Tempore

9. Was the conference call of February 20, 2003, a briefing that was required under state or federal law?
10. What draft language was submitted to the Governor's Task Force by or on behalf of FPIC or the Coalition to Health Florida's Health Care?
11. You indicated that one professional liability insurance carrier, Frontier, is no longer in Florida because they charged inadequate premiums. Did FPIC acquire Frontier's medical malpractice book of business? If so, when?
12. If FPIC did acquire Frontier's book of business, and if Frontier was charging inadequate premiums, how did this impact FPIC's losses when Frontier claims had to be paid under the FPIC umbrella?
13. If FPIC did acquire Frontier's book of business, please provide records of losses paid versus reserves under Frontier policies after Frontier was acquired by FPIC.
14. Provide us with a breakdown of the operating expenses of FPIC over the last 5 years.

We ask that you please provide the appropriate responsive documentation to the Senate Committee on Judiciary no later than **5:00 pm on Monday, August 4, 2003**. We recognize that you have already provided an affidavit to the committee that may in part answer these questions. If this is the case, please indicate so in your response. To aid you in your response, we have attached those pages of the transcript that contain your testimony. If you have any questions, please contact Judiciary Committee staff at (850) 487-5198.

Sincerely,

Senator Alex Villalobos
Chair

FPIC

Serving Healthcare Providers

1000 Riverside Ave. Suite 800
Jacksonville, FL 32204
800-741-3742 Fax (904) 358-6728

Fax

PERSONAL & CONFIDENTIAL

DATE: **August 4, 2003**

TO: **David Greenbaum, Esq.**

TELECOPIER NUMBER: **(850) 410-0082**

FROM: **Robert L. Wortelboer, Esquire**
General Counsel
First Professionals Insurance Company, Inc.

Please Reply To:
FPIC Legal Department
1000 Riverside Avenue, Suite 800
Jacksonville, Florida 32204
Phone (904) 354-5910 Ext. 3281
Fax (904) 358-6424

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

Remarks: **Please see that Mr. Greenbaum receives this facsimile ASAP. Thank you.**

OUR FACSIMILE NUMBER IS (904) 358-6424 **No. of Pages: 2**

Law on 'Serve_2' (E:) \FaxCover.doc

FPIC

Insurance Solutions for Healthcare Providers

Robert L. Wortelboer, Esquire
Senior Legal Counsel

August 4, 2003

Via Facsimile Transmission
and Regular U.S. Mail

Senator Alex Villalobos, Chairman
Florida Senate Committee On Judiciary
c/o David Greenbaum, Esquire
404 South Monroe Street
Tallahassee, Florida 32399-1100

Re: Confirmation of Agreement Concerning Extension of Time

Dear Mr. Greenbaum:

Please accept this letter as confirmation of our conversation on Friday morning August 1, 2003 wherein we agreed that First Professionals Insurance Company, Inc. would be granted an extension until 5:00 p.m., Monday August 18, 2003, to respond to the fourteen questions that were outlined in Senator Alex Villalobos' letter to our President, Robert E. White, Jr. dated July 29, 2003.

If you have any questions please do not hesitate to call me at (904) 354-5910 Ext. 3281 or on my cell phone at (904) 866-7026.

Sincerely,

Robert L. Wortelboer, Esquire
General Counsel
First Professionals Insurance Company, Inc.

Supplemental Addendum:

Florida Physician's Insurance Co., Inc.'s (FPIC) Response to Request for Additional Materials

(exclusive of Annual Statements from 1998 -2002 which were filed formerly with the Florida Department of Insurance and are available through the Office of Insurance Regulation)

FPIC®

Insurance Solutions for Healthcare Providers

Robert E. White, Jr.
President

August 15, 2003

Via Overnight Delivery

Senator Alex Villalobos
The Florida Senate
Committee on Judiciary
515 Knott Building
404 South Monroe Street
Tallahassee, Florida 32399-1100

Re: Response to Your Letter Dated July 29, 2003

Dear Senator Villalobos:

This letter is in response to your July 29, 2003 letter requesting additional information related to my testimony to the Senate Committee on Judiciary.

1. *Please provide the number of claims per 100 insured physicians for each year from 1996 through 2002.*

   The following table illustrates the number of claims per 100 insured physicians:

First Professionals Insurance Company
Physicians & Surgeons Professional Liability
Florida Only
As of 06/30/2003
Number of Claims per 100 Exposures Insured

Report Year	Number of Claims Per 100 Doctors
1996	8.1
1997	8.8
1998	9.0
1999	8.5
2000	9.7
2001	10.9
2002	11.0

1000 Riverside Avenue, Suite 800 • Jacksonville, FL 32204 • (904) 354-5910 • 1-800-741-3742 • Fax (904) 350-1009
Mailing address: P.O. Box 44033 • Jacksonville, FL 32231-4033
Internet Address: http://www.fpic.com

2. *Please provide the number of physicians insured by FPIC for each year from 1996 through 2002*

   The number of physicians insured by First Professionals Insurance Company ("FPIC") is as follows:

Physicians Insured by FPIC
Excludes Dentists, Allied and Fronted Policies

As of year end	All States	Florida
1996	4,229	4,227
1997	4,872	4,858
1998	5,028	5,003
1999	4,596	4,532
2000	4,398	4,264
2001	5,789	5,129
2002	7,273	5,848

3. *Please provide a copy of the contract or any other agreement between FPIC and the Florida Medical Association (FMA) regarding FPIC's payment of an endorsement fee to the FMA. If not so indicated in the contract, please indicate how long this endorsement relationship has been in existence. Please verify the total amount FPIC has paid the FMA for the period this agreement has been in effect.*

   There is currently in place an Endorsement Agreement ("Endorsement Agreement") between FPIC Insurance Group, Inc. ("FIG") and the Florida Medical Association ("FMA"). This Endorsement Agreement began on July 1, 2002 and is for a term of five years. A copy of the Endorsement Agreement is enclosed. FIG announced the Endorsement Agreement through an official press release on June 13, 2002. A copy of that press release is attached to this response. In conjunction with the Endorsement Agreement, FIG and the FMA have also entered into a Services Agreement effective July 1, 2002 for a term of five years, which is also enclosed. The purpose of the Services Agreement is to pay for marketing services associated with the Endorsement Agreement. The Endorsement Agreement replaced and superseded the previous endorsement agreement between the FMA and Florida Physicians Insurance Company, Inc. now known as First Professionals Insurance Company, Inc. ("FPIC") that went into effect on July 27, 1999 and which continued in effect through June 30, 2002. A copy of this endorsement agreement has also been enclosed.

A review of our records has failed to produce any additional written agreements concerning the endorsement of FPIC by the FMA prior to July 27, 1999. However, FIG has publicly reported the existence of an agreement by the FMA to endorse FPIC in each of its proxy statements for 1997 and 1998, which outline the basic terms and subsequent evolution of the FMA's endorsement of FPIC leading into the written agreements that have been produced pursuant to your request. In 1997, the proxy statement states that in recognition of the FMA's endorsement and marketing assistance, FPIC pays the FMA each year 1% of FPIC's net premium earned from physician medical professional liability insurance in Florida during that year. In 1998, the terms remained unchanged except that a limit of $500,000 was placed on the endorsement fee and the parties agreed to designate $50,000 of the endorsement fee in that year to the FMA Foundation to support the Physicians Recovery Network.

The existence of an FMA endorsement of FPIC and cooperation in marketing efforts prior to 1997 is likely but the existence and the terms of such an agreement is unknown at this time due to the unavailability of records and that fact that such agreements pre-date our current management.

4. *Please indicate to which other state medical associations FPIC, FPIC's holding company, or FPIC's sister companies make payment of an endorsement fee. Please indicate the amount of such fees and the period that the agreement has been in effect.*

   There is an Endorsement and Sponsorship Agreement in effect among FIG, The Florida Osteopathic Medical Association ("FOMA") and the insurance agency of Rogers, Atkins, Gunter & Associates Insurance, Inc. ("Rogers"). This Agreement has been and remains in effect since October 1, 2001. The fees paid by FIG to FOMA per year amount to approximately $12,000 plus one half of one percent (0.5%) up to two million dollars or one percent (1.0%) over two million dollars of the amount of collected premium from members insured by FPIC through the endorsement program. FIG also pays a one percent (1.0%) commission to Rogers for all business written by agents other than Rogers that are written through the endorsement program.

5. *Please provide a listing of FPIC's rate filings for the past five years, as reported to the Department of Insurance/Office of Insurance Regulation.*

   Attached hereto as Exhibit "A" is a list of FPIC's rate filings for the last five years. Copies of the detailed rate filings are available from the Florida Office of Insurance Regulation ("FOIR").

6. *Please define the term "allocated loss expenses." Please indicate what allocated loss expenses were accrued from FPIC's Florida operations.*

   Allocated Loss Adjustment Expenses are loss adjustment expenses that have been allocated to a specific claim. Loss adjustment expenses are defined in Statement of Statutory Accounting Principles No. 55, attached hereto as Exhibit "B".

   It is unclear to us what is being asked by the second part of this question. However, state specific information on losses and allocated loss adjustment expenses, both paid and incurred, is available on the state pages in the FPIC annual statements filed with the FOIR. Please note that we have enclosed copies of the annual statements for FPIC for the years 1998 through 2002.

7. *Please provide the details of how you discount certain physicians, including the criteria and the amounts of discounts. Include a detailed description of the "claims free" discount, i.e., how long does the physician need to remain claims free and what discount do they receive? Is that discount available in all specialties?*

   Please see the enclosed "Underwriting Rules".

8. *Does FPIC use experience rating? Or just the "claims free" discount?*

   In rare circumstances and only with very large groups, FPIC may take past experience into consideration when calculating prospective rates. In these circumstances, FPIC files consent to rate forms with the FOIR.

9. *Was the conference call of February 20, 2003, a briefing that was required under state or federal law?*

   The conference call of February 20, 2003 referenced in this question was conducted by FPIC Insurance Group, Inc., the publicly traded holding company of FPIC. It is routine for publicly traded companies to conduct a quarterly conference call with analysts and investors to review quarterly and/or full year financial results. These conference calls occur in conjunction with the filing of quarterly or annual reports with the Securities and Exchange Commission and the issuance of a press release of the quarterly and/or full year results. While the reporting of these results is required under federal law, the conference call is not specifically required but is a common business practice among publicly traded companies.

10. *What draft language was submitted to the Governor's Task Force by or on behalf of FPIC or the Coalition to Heal Florida's Health Care?*

    Enclosed are the materials that First Professionals Insurance Company, Inc. provided to the Governor's Task Force. I do not know what draft language was provided to the Governor's Task Force on behalf of the Coalition To Heal Florida's Health Care.

11. *You indicated that one professional liability insurance carrier, Frontier, is no longer in Florida because they charged inadequate premiums. Did FPIC acquire Frontier's medical malpractice book of business? If so, when?*

    During 1997, FPIC's holding company, FPIC Insurance Group, Inc. through its subsidiary FPIC Insurance Agency, Inc., acquired the renewal rights to the Florida book of medical professional liability business of Frontier Insurance Company (the "Frontier Agreement"). FPIC did not acquire any of the liabilities or loss reserves of Frontier Insurance Company. FPIC simply acquired the right to renew Frontier Insurance Company policies under FPIC rates and underwriting guidelines.

12. *If FPIC did acquire Frontier's book of business, and if Frontier was charging inadequate premiums, how did this impact FPIC's losses when Frontier claims had to be paid under the FPIC umbrella?*

    The Frontier Agreement was an agreement to purchase the renewal rights to medical professional liability policyholders insured with Frontier Insurance Company in the State of Florida. The Frontier Agreement did not involve the assumption of the liabilities or future losses of Frontier Insurance Company. Any insured previously with Frontier had to meet FPIC's underwriting criteria and was charged FPIC rates.

13. *If FPIC did acquire Frontier's book of business, please provide records of losses paid versus reserves under Frontier policies after Frontier was acquired by FPIC.*

    Not applicable. See 11. and 12. above.

14. *Provide us with a breakdown of the operating expenses of FPIC over the last 5 years.*

    A detailed breakdown of the operating expenses of First Professionals Insurance Company is available in the Underwriting and Investment Exhibits (Part 3 in 2002, Part 4 for 2001 and earlier) of the FPIC annual statements filed with the FOIR. Please note that we have included copies of the annual statements for FPIC from 1998 through 2002.

Thank you for the opportunity to respond to your questions.

Sincerely,

Robert E. White, Jr.
President
First Professionals Insurance Company, Inc.

EXHIBIT "A"

As requested by the Florida Senate, I have detailed the rate filing activity for First Professionals Insurance Company (formerly known as Florida Physicians Insurance Company, Inc.). The history includes those filing which had an impact on manual premium. It does not include underwriting rule or form filings.

1. **Effective 1/1/1998:** FPIC filed and received approval to increase the underlying base rate 5.5%. In addition, we modified territory factors in Palm Beach and Dade Counties and changed various class relativities. This filing resulted in an average overall increase of 7.3%.

2. **Effective 1/1/1999:** FPIC filed and received approval to increase the underlying base rate 6.2%. In addition, we modified several class and territory relativities. This resulted in an average overall change of 8.5%

3. **Effective 1/1/2000**: FPIC filed and received approval for several modification to their rating variables. The changes impacted class relativities, territories, discounts and expenses. This resulted in a average overall 0.0% change to premium.

4. **Effective 6/1/2000:** FPIC filed and received approval for a modification to their increased limit factors. The average increase of 9.7% impacted policy limits of $500,000 or greater.

5. **Effective 1/1/2001**: FPIC filed and received approval to increase the underlying base rate 10.7%. In addition, we combined several additional coverages into the physician's medical malpractice policy. This included coverage for ACHA, accidental death & dismemberment coverage (UNUM) and financing charges. The total premium impact of this rate filing was 12.7%

6. **Effective 12/01/2001**: FPIC filed and received approval to increase the underlying base rate 19.5%. In addition, FPIC changed several class relativities and modified increased limit factors 10% on all policy limits of $1 million or greater. This filing resulted in an average overall increase of 28.1%.

7. **Effective 12/01/2002**: FPIC filed and received approval to increase the underlying base rate 17.0%. FPIC made several additional changes. First, they created two new territories, Jacksonville Area and an additional South Florida territory. Second, the 1st year claims made factor was increased from .25 to .30. Finally, FPIC consolidated their class structure which resulted in several changes to class relativities. In all, the increase to premium was 21.1%.

EXHIBIT "B"

SSAP No. 55
Unpaid Claims, Losses and Loss Adjustment Expenses

STATUS

Type of Issue:	Common Area
Issued:	Initial Draft
Effective Date:	January 1, 2001
Affects:	No other pronouncements
Affected by:	No other pronouncements
Interpreted by:	INT 00-31

SUMMARY CONCLUSION

4. Claims, losses, and loss/claim adjustment expenses shall be recognized as expense when a covered or insured event occurs. In most instances, the covered or insured event is the occurrence of an incident which gives rise to a claim or the incurring of costs. For claims made type policies, the covered or insured event is the reporting to the entity of the incident that gives rise to a claim. Claim payments and related expense payments are made subsequent to the occurrence of a covered or insured event and, in order to recognize the expense of a covered or insured event that has occurred, it is necessary to establish a liability. Liabilities shall be established for any unpaid claims and unpaid losses (loss reserves), unpaid loss/claim adjustment expenses (loss/claim adjustment expense reserves) and incurred costs, with a corresponding charge to

income.

5. The following are types of future costs relating to property and casualty contracts, as defined in SSAP No. 50, which shall be considered in determining the liabilities for unpaid losses and loss adjustment expenses:

a. Reported Losses: Expected payments for losses relating to insured events that have occurred and have been reported to, but not paid by, the reporting entity as of the statement date;

b. Incurred But Not Reported Losses (IBNR): Expected payments for losses relating to insured events that have occurred but have not been reported to the reporting entity as of the statement date. As a practical matter, IBNR may include losses that have been reported to the reporting entity but have not yet been entered to the claims system or bulk provisions. Bulk provisions are reserves included with other IBNR reserves to reflect deficiencies in known case reserves;

c. Loss Adjustment Expenses: Expected payments for costs to be incurred in connection with the adjustment and recording of losses defined in subparagraphs 5 a. and 5 b. Examples of expenses incurred in these activities are estimating the amounts of losses, disbursing loss payments, maintaining records, general clerical, secretarial, office maintenance, occupancy costs, utilities, computer maintenance, supervisory and executive duties, supplies, and postage. Loss adjustment expenses can be classified into two broad categories: Defense and Cost Containment (DCC) and Adjusting and Other (AO):

i. DCC include defense, litigation, and medical cost containment expenses, whether internal or external. DCC include, but are not limited to, the following items:
   (a) Surveillance expenses;
   (b) Fixed amounts for medical cost containment expenses;
   (c) Litigation management expenses;
   (d) Loss adjustment expenses for participation in voluntary and involuntary market pools if reported by accident year;
   (e) Fees or salaries for appraisers, private investigators, hearing representatives, reinspectors and fraud investigators, if working in defense of a claim, and fees or salaries for rehabilitation nurses, if such cost is not included in losses;
   (f) Attorney fees incurred owing to a duty to defend, even when other coverage does not exist; and
   (g) The cost of engaging experts;

ii. AO are those expenses other than DCC as defined in (i) above assigned to the expense group "Loss Adjustment Expense." AO include, but are not limited to, the following items:
   (a) Fees and expenses of adjusters and settling agents;
   (b) Loss adjustment expenses for participation in voluntary and involuntary market pools if reported by calendar year;
   (c) Attorney fees incurred in the determination of coverage, including litigation between the reporting entity and the policyholder; and
   (d) Fees and salaries for appraisers, private investigators, hearing representatives, reinspectors and fraud investigators, if working in the capacity of an adjuster.

Original
Contract

ENDORSEMENT AND SPONSORSHIP AGREEMENT

This Endorsement and Sponsorship Agreement ("Agreement") is made this 1st day of October, 2001 (the "Effective Date") among FPIC Insurance Group, Inc. ("FIG"), a Florida corporation with a principal place of business at 225 Water Street, Suite 1400, Jacksonville, Florida 32202; The Florida Osteopathic Medical Association ("FOMA"), a Florida not-for-profit corporation with a principal place of business at 2007 Apalachee Parkway, Tallahassee, Florida 32301; and Rogers, Atkins, Gunter & Associates Insurance, Inc. ("RAGA") with a principal place of business at 1117 Thomasville Road, Tallahassee, Florida 32303.

WHEREAS, FIG provides medical professional liability insurance to physicians and other health care providers through its wholly-owned subsidiary First Professionals Insurance Company, Inc. (previously known as Florida Physicians Insurance Company and herein referenced as "FPIC"), which is a licensed insurance carrier in the state of Florida, and

WHEREAS, FOMA is an association of physicians specializing in the field of osteopathic medicine, and

WHEREAS, RAGA is an insurance agency which serves as the endorsed agency and administrator of FOMA's professional liability insurance program that is the subject of this Agreement;

WHEREAS, FPIC desires to increase its market share by having greater access to FOMA members, and

WHEREAS, FOMA desires to facilitate the ability of its members to purchase professional liability insurance at competitive rates and ensure its financial stability;

NOW, THEREFORE, in consideration of the mutual promises of the parties herein contained, and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties do hereby agree as follows:

1. Nature of Agreement.

Under the terms of this Agreement, FOMA is granting an exclusive endorsement of FPIC's professional liability insurance program (hereinafter "Program"), which will be actively marketed to FOMA members in Florida through FPIC, FOMA, and RAGA. Under this Program, FPIC shall be the exclusively endorsed provider of professional liability insurance for FOMA members and RAGA shall be the exclusively endorsed agent for this line of business.

2. Program Description

a. In General. The Program, which is the subject of this Agreement, will offer professional liability insurance coverage to eligible members of FOMA at discounted rates. The rates shall be promulgated based upon discount factors applied to FPIC's standard rates as filed annually with the Florida Department of Insurance. The existence of a Program discount will be noted on all FPIC statements to FOMA members eligible for the discount and insured by FPIC. The Program discount shall be as follows:

Program discount: 7.5%

In addition, FPIC's claims-free program currently allows for the following discounts: 25% discount if claims-free for 15+ years; 20% discount if claims-free for 10-14 years; 10% discount if claims-free for 5-9 years. Eligible FOMA members may receive their claims-free discounts after accessing their Program discount. FPIC's claims-free program shall be consistent with its claims-free program on file with the Florida Department of Insurance as amended from time to time.

b. Coverage - Professional liability insurance coverage will be afforded through a modified claims-made policy form, under a risk classification system filed with the Florida Department of Insurance. Program participants (eligible FOMA members) may choose one of the following limits of liability:

$250,000 per claim / $750,000 annual aggregate
$500,000 per claim / $1,500,000 annual aggregate
$1,000,000 per claim / $3,000,000 annual aggregate
$1,500,000 per claim / $4,500,000 annual aggregate
$2,000,000 per claim/ $5,000,000 annual aggregate

Incorporated practices may be named as additional insureds with shared limits of liability at no additional premium. Coverage for employees may be added in accordance with standard rates and rules as filed with the Florida Department of Insurance. All rates, rules, and forms promulgated for use with FPIC's standard professional liability business will be utilized in providing a total program for FOMA and its eligible members.

c. Rates. FPIC reserves the right to modify its rates subject to the approval of the Florida Department of Insurance. FPIC's discounts (other than the FOMA Program discount) and osteopathic physician relativities are subject to change at the discretion of FPIC and the FOMA Program discount will be evaluated annually based upon experience and may decrease or discontinue at the discretion of FPIC based upon said evaluation. FPIC shall provide written notice regarding osteopathic physician relativity changes to FOMA and RAGA at least forty-five (45) days prior to the effective date of any rate change.

d. Eligibility for the Program Eligibility for the Program shall include physicians who are members in good standing with FOMA who are eligible for FPIC's standard policy program based upon FPIC's underwriting discretion. FOMA members eligible for this Program who are already insured by FPIC shall be eligible for this Program upon renewal following the effective date of this Agreement. FOMA members who are insured by FPIC in its non-standard program shall not be eligible for the discounts provided in the Program. However, once a FOMA member insured in FPIC's non-standard program becomes eligible for and insured in FPIC's standard policy program the member shall then be eligible for the discounts provided in the Program.

If RAGA submits an application for insurance to FPIC through the Program and an AOR (agent of record) is subsequently submitted by another agent, the applicant will not be eligible for the Program discount through the agency submitting the AOR. In addition, if an agent other than RAGA submits an AOR on current business that is in the Program through RAGA that insured will not be eligible for the Program discount at renewal through said other agent. However, under both of these forgoing circumstances, FPIC shall be permitted to offer the insured other discounts through other FPIC programs in effect at that time. If an agent other than RAGA submits an application for an eligible insured through the Program the applicant will be entitled to the Program discount and RAGA shall receive the override commission set forth in Section 4(e) of this Agreement.

e. Administration Duties of RAGA RAGA shall serve as the marketing administrator of the FOMA professional liability program that is the subject of this Agreement. These duties shall include but not be limited to oversight and responsibility for the duties of FOMA and RAGA under this Agreement.

3. Payment of Premiums.

FPIC will handle all billing and collection of premiums. Policyholders may pay their premium on an annual basis or on a periodic basis using FPIC's periodic payment plan. The periodic payment plan requires a down payment and subsequent monthly payments.

4. Additional Items

a. Compensation, Annual Meeting. FIG and RAGA shall share the following annual meeting contributions in accordance with Exhibit A, which is hereby made part of and incorporated into this Agreement:

i. Ten thousand dollars ($10,000.00) for an educational grant;

ii. Two thousand dollars ($2,000.00) for an annual FOMA board of trustees meeting grant;

iii. One thousand four hundred dollars ($1,400.00) for an annual meeting booth rental in the first year of this Agreement. The parties further agree that the annual meeting booth rental for every year thereafter shall not increase more than (25%) twenty-five percent for FPIC from the previous year and any increase above this percentage shall be paid by RAGA.;

iv. Five hundred dollars ($500.00) for annual meeting costs associated with a booth drawing prize and FPIC/RAGA pre-meeting promotional materials (it shall be RAGA's responsibility to purchase the booth drawing prize). The parties agree that the $500.00 dollars contribution shall be split such that $300.00 dollars is spent toward the purchase of the booth drawing prize and $200.00 dollars is spent toward the pre-meeting promotional materials.;

v. One thousand dollars ($1,000.00) for a FOMA executive committee dinner; and

vi. Five hundred dollars for a Grand Prize Drawing (FOMA will choose the prize valued at five hundred dollars ($500.00)).

b. Compensation, Mid-Year Meeting. FIG and RAGA shall share the following Mid-Year meeting contributions in accordance with Exhibit A:

i. Eight hundred dollars ($800.00) for the rental fees associated with an exhibit booth in the first year of this Agreement. The parties further agree that the Mid-Year meeting booth rental for every year thereafter shall not increase more than (25%) twenty-five percent for FPIC from the previous year and any increase above this percentage shall be paid by RAGA.;

ii. Eight hundred and fifty dollars ($850.00) for two Grand Prizes (two annual FOMA membership dues) in the first year of this Agreement to be distributed and marketed at the FPIC/RAGA exhibit booth. In each year thereafter, the amount of the prize will be equal to two times (for two annual FOMA membership dues) the amount of membership dues of FOMA that exist at that time. ;

iii. Five hundred dollars ($500.00) for a Legislative Day Educational Grant; and

iv. Five hundred dollars ($500.00) for costs associated with a booth drawing prize and FPIC/RAGA pre-meeting promotional materials (it shall be RAGA's responsibility to purchase the booth drawing prize). The parties agree that the $500.00 dollars contribution shall be split such that $300.00 dollars is spent toward the purchase of the booth drawing prize and $200.00 dollars is spent toward the pre-meeting promotional materials.

FPIC and RAGA shall receive exhibit space with priority placement in the applicable exhibit area at FOMA's annual and mid-year meetings. FPIC and RAGA shall each be permitted to have its own full one-page ad in FOMA's annual and mid-year meeting publication that is distributed to its members. No other professional liability carrier or agency offering professional liability insurance will be permitted to exhibit or to place any ad in the FOMA annual and mid-year meeting publication except for the American Osteopathic Association (AOA) Sponsored Program Provider in accordance with an agreement between FOMA and the AOA. In addition, FPIC and RAGA shall be recognized at the highest level of sponsorship at FOMA's annual and mid-year meetings.

c. FOMA Publications. FIG and RAGA shall share the following FOMA publications contributions in accordance with Exhibit A:

i. Two thousand dollars ($2,000.00) toward the publication of the FOMA Journal; and

ii. Five hundred dollars ($500.00) toward the cost of the FOMA Year Book & Directory.

FPIC and RAGA shall each receive a full one-page advertisement in each FOMA Journal and each FOMA Year Book & Directory during the term of this Agreement. FPIC and RAGA shall be, respectively, the only professional liability insurance carrier and the only agent offering this line of business permitted to advertise in each of these publications, except for the AOA sponsored program provider. In addition, FPIC and RAGA shall have the right to publish a Program-related article in all FOMA Journals and FOMA newsletters to its members, the content of which shall be subject to the approval of FOMA.

d. Website Contribution & Presidential Ring Award FIG and RAGA shall share the following FOMA Website and Presidential Ring Contributions in accordance with Exhibit A:

i. Three thousand dollars ($3,000.00) toward the cost of operating the FOMA Website; and

ii. One thousand seven hundred dollars ($1,700.00) to sponsor the FOMA Presidential Ring that is given annually.

FPIC and RAGA shall each receive a link from the FOMA website. FPIC and RAGA shall be, respectively, the only professional liability insurance carrier and the only agent offering this line of business permitted to have a link from the FOMA website, except for any AOA sponsored program provider.

e. Non-Dues Compensation. FIG shall also pay FOMA one half of one percent (0.5%) of all new collected premium from eligible members insured through the Program. Any funds owed to FOMA using the one half of one percent (0.5%) calculation shall be paid within thirty (30) days of the close of each contract year. Once new collected premium from eligible members insured through the Program is greater than or equal to two million dollars ($2,000,000.00) in any one contract year, non-dues revenue owed to FOMA by FIG on the entire amount of new collected premium in that contract year will increase to one percent (1%). The contract year shall begin on the effective date of this Agreement and end on the next anniversary of said date the following year. For the purposes of this Section 4(e), the term "new" shall be limited to collected premium from FOMA insureds in the Program insured with FPIC's standard policy for a given contract year and specifically excludes premium from any physicians already insured with FPIC that rolls over into the Program during the term of this Agreement.

f. Override Commission & Referral of Leads FIG shall pay a one percent (1.0%) override commission to RAGA for all business written by agents other than RAGA through the Program. All leads brought to FPIC directly through the Program shall be forwarded to RAGA for follow up.

g. Annual Meeting Presentation. A FPIC and RAGA representative shall attend a portion of the FOMA annual meeting and mid-year meeting of its Executive Committee and/or Board of Trustees for the purpose of providing an update on the program and to respond to questions.

h. Risk Management. FPIC and FOMA agree to jointly develop a risk management program. As part of this program, FPIC shall provide free office surveys to any FOMA member insured with FPIC.

5. Party Responsibilities Under the Program

a. Marketing. FPIC and RAGA may market to FOMA members and non-member osteopathic physicians either through direct mail solicitations or through insurance agents. Any written material utilized in either approach that makes reference to FOMA shall be consistent with the terms of this Agreement and approved by FOMA.

b. Agent Solicitations. FPIC currently licenses a number of agents in the State of Florida. FPIC agents will act on behalf of the Company in acquiring business that may be submitted through the Program. Except for those rights and responsibilities specifically reserved for RAGA under this Agreement including marketing administration duties, FOMA agrees to allow licensed agents the same rights and privileges that FPIC enjoys in using the FOMA name in any solicitation. Except for those duties specifically obligated to be performed by RAGA under this Agreement, FPIC shall maintain full rights and controls as to the actions of its licensed agents in accordance with the contract that FPIC maintains with each agent or agency that represents them.

c. Agent Remuneration. FPIC retains full rights and responsibilities for all commission payments to licensed agents.

d. Member and Non-Member Mailings. FOMA shall provide RAGA and FPIC on a quarterly basis with a current and updated mailing list (or electronic media) of FOMA members and osteopathic physician nonmembers in the State of Florida, when available, free of charge. "Mailing lists" means updated and current lists, electronic media (in a format agreeable to both FPIC and FOMA or RAGA and FOMA) and/or labels containing names, postal addresses, and telephone numbers of Members segmented by zip codes or reasonably selected membership characteristics. FOMA will provide letterhead and envelopes and FPIC and RAGA shall pay postage expenses associated with such mailings.

e. Advisory Board The parties shall implement an advisory board consisting of six members to serve as a liaison group. FOMA shall provide RAGA and FPIC with the names of three osteopathic physician members who shall serve on the advisory board. FPIC will provide two names to serve on the board on their behalf and RAGA shall provide one name to serve on the board on their behalf. The board will meet or otherwise communicate as needed to serve the intent and purpose of this Agreement.

6. Underwriting of Policyholders.

FOMA understands and agrees that membership in FOMA does not guarantee that FPIC will issue a policy to all members. FPIC agrees that it will use normal underwriting standards and practices to review and select potential policyholders.

7. Term and Termination.

This Agreement shall be effective as of the Effective Date above first written and shall remain in effect until terminated pursuant to the provisions herein. Notwithstanding the above, any party may cancel the Agreement for good cause (defined as breach of this Agreement, which remains uncured for at least 30 days after the provision of notice of such breach) upon 30 days notice to the other parties or for no cause upon any anniversary date of this Agreement, provided that notice is sent to the other parties no later than sixty (60) days prior to such anniversary date.

8. Amendments.

This Agreement may be modified or amended only in writing executed by all parties to this Agreement.

9. Governing Law.

The validity, construction, and performance of this Agreement shall be governed and construed in accordance with the laws of the State of Florida.

10. Mediation.

The parties hereby agree to attempt to settle any and all disputes arising out of this Agreement through good faith attempts to settle such differences. Should any such disputes not be resolved through negotiation, all parties agree to submit such disputes to a certified court mediator prior to initiating any litigation. If a settlement is not reached within ninety (90) days of the submission of a case for mediation, one or more parties may then initiate litigation related to such dispute.

11. Severability.

If any provision of this Agreement is found to be invalid or unenforceable under any applicable law, that provision shall be enforced to the extent permissible, and the remaining provisions of this Agreement shall remain in full force and effect.

12. Non-Waiver.

No failure or delay by any party in exercising any right or remedy under this Agreement shall waive any provision of this Agreement, nor shall any right or remedy under this Agreement preclude any party from otherwise or further exercising these rights or remedies, or any other rights or remedies granted by law or any related document.

13. Captions.

The headings in this Agreement are for convenience only and do not affect the interpretation of this Agreement.

14. Entire Agreement.

This Agreement constitutes the entire agreement between the parties hereto and supersedes all previous and contemporaneous oral and written negotiations, agreements, undertakings, or other commitments. No covenant or condition not expressed in this Agreement or incorporated herein by reference shall affect or be effective to interpret, change, or restrict this Agreement.

15. Notices.

All notices and other communications required or permitted under this Agreement shall be in writing and shall be (i) hand-delivered, or (ii) sent by registered or certified first class mail, postage prepaid, or sent by nationally recognized express courier service. Such notices and other communications shall be effective upon receipt, and shall be sent to all parties at the address below:

If to FIG or FPIC: Gary F. Izzo
Vice President of Marketing
1000 Riverside Avenue, Suite 800
Jacksonville, FL 32204

If to FOMA: Stephen R. Winn
Executive Director
Florida Osteopathic Medical Association
2007 Apalachee Parkway
Tallahassee, Florida 32301

If to RAGA: William D. Gunter, Jr.
Chairman & Chief Executive Officer
Rogers, Atkins, Gunter & Associates Insurance, Inc.
1117 Thomasville Road
Tallahassee, Florida 32303

16. Counterparts

This Agreement may be executed in counterparts which, when combined either by original or facsimile, shall have the same force and effect as an original signed by all parties to this Agreement.

17. Confidentiality

a. Any material expressly deemed to constitute "confidential information" pursuant to this Agreement shall, unless indicated otherwise below, remain offered to the other parties for the sole purpose of fulfilling the terms of this Agreement, and may not be used for any other purpose or disclosed to any other party without the expressed written consent of the transmitting party

b. As used herein, the term "confidential information" shall mean all information that is transmitted to other parties relative this Agreement.

c. Each party shall utilize any received confidential information only for the purposes described in this Agreement and, upon the termination of this Agreement, shall return to the transmitting party any and all copies of confidential information not needed for purposes of this Agreement.

d. The party receiving confidential information hereunder shall be held to the same standard of care in protecting such information as the receiving party normally employs to preserve and safeguard its own confidential information of a similar kind.

18. Disclosure of Endorsement

During the term of this Agreement, the parties shall have the right to disclose in any advertising, promotions, articles, or other written, oral, or electronic communications the fact that FPIC and/or RAGA has been endorsed by FOMA on an exclusive basis as a provider of professional liability insurance and as an agent for this line of business, respectively.

19. Use of FOMA Trademark

FOMA warrants and represents that it has the right and power to license the Trademarks to FPIC and RAGA for use as contemplated by this Agreement. FOMA hereby grants FPIC and RAGA a limited, nonexclusive license to use its Trademarks in conjunction with the Program, including the promotion thereof. This license shall terminate automatically upon the expiration or termination of this Agreement. Nothing stated in this Agreement prohibits FOMA from granting to other persons a license to use the Trademark in conjunction with the provision of any other service or product. For the purposes of this Agreement, "Trademarks" shall mean any logo, servicemark, tradename, or trademark personally used or acquired by FOMA during the term of this Agreement.

20. Complaints

Each party to this Agreement agrees to forward to the party that is (or the parties that are) the subject of any complaint, within thirty (30) days of receipt, a copy of each and every written complaint, whether or not justified, received by the receiving party relating to or arising in any manner whatsoever from the operations of this Agreement or the consummation of the transactions contemplated by this Agreement. The receiving party agrees to keep all information provided confidential in accordance with the terms of this Agreement.

21. Indemnification

Each party to this Agreement (the "indemnifying party or parties") agrees to indemnify and hold harmless each other party (the "indemnified party or parties") to this Agreement from all claims, loss, damage, liability, judgments, or settlements, including reasonable costs, expenses, and attorneys' fees arising out of the relationships of the parties under this Agreement and caused by the indemnifying party's or parties' bad faith, willful misfeasance, gross negligence, or reckless disregard of its duties or failure to comply with the terms of this Agreement. The indemnifying party or parties shall be liable to and shall pay the indemnified party or parties (within thirty [30] days for any payment made by the indemnified party or parties) for all expenses or damages suffered by the indemnified party or parties as a result of the indemnifying party's or parties alleged failure to comply with any applicable insurance regulatory laws.

IN WITNESS WHEREOF, the parties have executed this Agreement as of the Effective Date of this Agreement.

FPIC INSURANCE GROUP, INC.

Gary F. Izzo — Date: 10/1/01
Vice President of Marketing
Florida Physicians Insurance Company, Inc.
On Behalf of
FPIC Insurance Group, Inc.

FLORIDA OSTEOPATHIC MEDICAL ASSOCIATION

Stephen R. Winn, Executive Director — Date: 9/26/01

ROGERS, ATKINS, GUNTER & ASSOCIATES INSURANCE, INC.

William D. Gunter, Jr. — Date: 9-26-01
Chairman & Chief Executive Officer

EXHIBIT A

Amounts owed for items set forth in Section 4(a) through 4(d) of this Agreement total twenty-five thousand two hundred and fifty dollars ($25,250.00) of which FIG owes twelve thousand dollars ($12,000.00) and RAGA owes thirteen thousand two hundred and fifty dollars ($13,250.00). Both FIG and RAGA shall make payments as set forth below.

Contributions	Paid by RAG&A	Paid by FPIC	Payment Due by FPIC
Annual Meeting Contribution			
Educational Grant	$5,000	$5,000	Monthly installment
Board of Trustee Grant	$1,000	$1,000	Monthly installment
Annual Meeting Booth	$700	$700	Monthly installment
Annual Meeting (Booth Drawing Prize)	$500	0	At time of Meeting (FPIC & RAGA will both be a noted sponsor)
Executive Comm. Dinner	$500	$500	Monthly installment
Grand Prize Drawing	0	$500	Monthly installment (FPIC & RAGA will both be a noted sponsor)
Mid-Year Meeting Contribution			
Booth space	$400	$400	Monthly installment
Two FOMA Membership prizes	$425	$425	Monthly installment
Legislative Day Grant	0	$500	Monthly installment (FPIC & RAGA will both be a noted sponsor)
Mid-Year Meeting (Booth Drawing Prize)	$500	0	At time of Meeting (FPIC & RAGA will both be a noted sponsor)
Publications			
FOMA Journal	$1,000	$1,000	Monthly installment
Year Book & Directory	$250	$250	Monthly installment
FOMA Website			
Website Contribution	$2,125	$875	Monthly installment
Presidential Ring			
Presidential Ring Award	$850	$850	Monthly installment
Total	$13,250	$12,000	$1,000 paid monthly by FIG to FOMA $1,020.83 paid monthly by RAGA to FOMA

The parties further agree and understand that the above numbers reflect amounts owed for the first year of this Agreement. In accordance with the terms of this Agreement, the parties acknowledge that amounts for FOMA membership dues and exhibit hall space may increase causing an increase in the total amount owed by RAGA and FPIC to FOMA. In such event, the monthly payments made by FPIC and RAGA to FOMA shall increase accordingly.

Original Contract

ENDORSEMENT AGREEMENT

This Endorsement Agreement (the "Agreement") is made this 1st day of July 2002, (the "Effective Date") between FPIC Insurance Group, Inc. (hereinafter referred to as "FIG"), a Florida corporation with a principal place of business at 225 Water Street, Suite 1400, Jacksonville, Florida 32202, the Florida Medical Association, Inc. (hereinafter referred to as "FMA"), a Florida non profit corporation with a principal place of business at 113 East College Avenue, Tallahassee, Florida 32301. The parties acknowledge that this Agreement hereby replaces and supersedes the previous endorsement agreement between the FMA and FIG's subsidiary Florida Physicians Insurance Company, Inc. now known as First Professionals Insurance Company, Inc. (hereinafter referred to as "FPIC") that was effective on July 27, 1999 and which continued in effect through June 30, 2002.

WHEREAS, FIG provides medical professional liability insurance to physicians and other health care providers through its wholly owned subsidiary FPIC, which is a licensed insurance carrier in the state of Florida, and

WHEREAS, The Florida Medical Association serves as an advocate for Florida physicians and their patients to promote the public health, to ensure high standards in medical education and ethics, and to enhance the quality and availability of health care, and

WHEREAS, FMA desires to provide certain marketing services to FPIC through FMA Services by and through a separate agreement between FIG and FMA Services to promote FPIC's medical professional liability program as set forth herein; and

WHEREAS, FIG desires for FMA to endorse FPIC on an exclusive basis as a provider of professional liability insurance and FMA wishes to so endorse FPIC; and

WHEREAS, FMA and FIG desire to enter into a contract providing for endorsement of FPIC and FPIC's programs as described in this Agreement on the terms and conditions herein set forth.

NOW, THEREFORE, and in consideration of the mutual covenants contained herein, the parties agree as follows:

1. The Program

A. Nature of the Agreement. Under the terms of this Agreement, FMA is granting an exclusive endorsement of FPIC's professional liability insurance program (hereinafter "Program"), which will be marketed to FMA's members pursuant to a separate agreement between FMA Services and FIG. Under this Program, FPIC shall be the exclusively endorsed provider of professional liability insurance for FMA members.

B. Program Description. The Program, which is the subject of this Agreement, will offer professional liability insurance coverage to eligible members of FMA at discounted rates. The rates shall be promulgated based upon discount factors applied to FPIC's standard rates as filed with the Florida Department of Insurance. The existence of a Program discount will be noted on all FPIC statements to FMA members eligible for the discount and insured by FPIC. FPIC will provide a (5%) five percent FMA membership discount (the "Program Discount").

In addition, FPIC's claims-free program currently allows for the following discounts: 25% discount if claims-free for 15+ years; 20% discount if claims-free for 10-14 years; 10% discount if claims-free for 5-9 years. Eligible FMA members may receive their claims-free discounts after accessing their Program Discount, but may not combine other program discounts otherwise available through organizations other than the FMA. FPIC's claims-free program shall be consistent with its claims-free program on file with the Florida Department of Insurance as amended from time to time. The existence of an FMA discount will be noted on all FPIC statements to FMA members insured by FPIC.

C. Coverage. Professional liability insurance coverage will be afforded through a modified claims-made policy form, under a risk classification system filed with the Florida Department of Insurance. Program participants (eligible FMA members) may choose one of the following limits of liability:

$250,000 per claim / $750,000 annual aggregate
$500,000 per claim / $1,500,000 annual aggregate
$1,000,000 per claim / $3,000,000 annual aggregate
$1,500,000 per claim / $4,500,000 annual aggregate
$2,000,000 per claim/ $5,000,000 annual aggregate

Incorporated practices may be named as additional insureds with shared limits of liability at no additional premium. Coverage for employees may be added in accordance with standard rates and rules as filed with the Florida Department of Insurance. All rates, rules, and forms promulgated for use with FPIC's standard professional liability business will be utilized in providing a total program for FMA and its eligible members.

D. Rates. FPIC reserves the right to modify its rates subject to the approval of the Florida Department of Insurance. FPIC's discounts and physician relativities are subject to change at the discretion of FPIC and the FMA Program discount will be evaluated on an on-going basis based upon experience and may decrease or discontinue at the discretion of FPIC based upon said evaluation. FPIC shall provide written notice regarding physician relativity changes to FMA at least forty-five (45) days prior to the effective date of any rate change.

E. Eligibility for the Program. Eligibility for the Program shall include physicians who are members in good standing with FMA who are eligible for FPIC's standard policy program based upon FPIC's underwriting discretion. FMA members eligible for this Program who are already insured by FPIC shall be eligible for this Program upon renewal on and following the Effective Date of this Agreement. FMA members insured in accordance with FPIC's non-standard policy shall be excluded from any benefit offered under this Agreement including but not limited to any Program Discount. However, once a FMA member insured in FPIC's non-standard program becomes eligible for and insured in FPIC's standard policy program the member shall then be eligible for the discounts provided in the Program.

F. Underwriting of Policyholders. FPIC shall retain the right to select insureds for the Program from solicitations to the members of FMA and will also maintain ownership of any and all pieces of business generated from this program. FMA understands and agrees that membership in FMA does not guarantee that FPIC will issue a policy to all members. FPIC agrees that it will use normal underwriting standards and practices to review and select potential policyholders.

2. Duties of the Parties

A. Fees

(i.) Quarterly Fees. During the term of this Agreement, FIG shall pay to FMA an endorsement fee in the amount of ($120,000) one hundred and twenty thousand dollars on a calendar year quarterly basis, payable within ten (10) days after the end of each quarter. The first such payment shall be payable with respect to the quarter ending September 30, 2002.

(ii.) FMA CME Cruise. During 2002, FIG shall contribute a total of ($7,500) seven thousand five hundred dollars to be used (1) for certain FPIC employees to attend the Continuing Medical Education FMA cruise, including Cliff Rapp, who will be a CME presenter free of charge, and (2) to help sponsor the FMA's welcome receptions at this event.

(iii.) Online CME. During 2002, FPIC will exercise its best efforts to work with FMA to provide CME credits on-line to FMA members.

B. Legislative Matters. During the term of this Agreement, FIG/FPIC shall assist FMA with respect to the monitoring of legislative matters. Notwithstanding any other provision, payments made pursuant to this Agreement shall not be made for the purpose of having the FMA provide the types of activities described within Section 162(e) of the Internal Revenue Code, as amended in 1986, and/or the Regulations promulgated thereunder.

C. Meetings. FMA shall provide FPIC with free exhibit space with priority placement for FPIC at FMA's annual meeting. No other professional liability carrier offering professional liability insurance will be permitted to exhibit or in any way advertise or promote itself at the FMA's annual meeting or any other meeting, function or event conducted or sponsored by the FMA. Moreover, FPIC will be permitted to provide featured speakers at FMA annual and quarterly meetings on topics to be mutually agreed upon. FPIC shall be recognized at the highest level of sponsorship at all FMA meetings and events.

D. FMA Publications. During the term of this Agreement, FMA shall not permit any advertising or promotion in FMA periodicals or FMA meetings of any professional liability insurance offered by any other insurance carrier. FPIC shall be permitted, without charge, to have its own full one-page ad in the FMA's annual meeting publication and any other publication distributed to its members at any quarterly meeting. FPIC shall also be permitted to have its own full one page ad, without charge, in each issue of the *FMA Journal* and shall also be permitted, without charge, to have its own advertisement and industry related article in all other publications of the FMA distributed to its members including but not limited to the FMA's newsletters.

E. Board of Director Meeting Presentations. FMA shall permit a FPIC representative to attend a portion of all FMA board of directors meetings for the purpose of providing an update on the program and to respond to questions.

F. Risk Management. FPIC and FMA agree to jointly develop a risk management program for physicians that would permit members to achieve continuing medical education credits. As part of this program, FPIC shall provide free office surveys to any FMA member insured with FPIC.

G. FMA Web Page. FMA shall provide a link on its home web page to the FIG website. FPIC shall be the only professional liability insurance carrier permitted to have a link from the FMA web site. In addition, FPIC shall be the only professional liability carrier endorsed throughout the FMA website.

H. Marketing. FMA, including its officers, directors, and staff, shall endorse the sale of FPIC's products/services as described in this Agreement to its membership through membership mailings and/or articles in FMA periodicals and other media as FMA and FPIC jointly agree. FMA agrees to direct FMA member inquiries regarding the product/service to FPIC. FPIC may market to FMA members either through direct mail solicitations or through insurance agents. Any written material utilized in either approach that makes reference to FMA's endorsement shall be made in accordance with this Agreement.

I. List Development and Maintenance. FMA shall make available to FPIC a list of FMA members and non-member physicians (practicing in the state of Florida), which shall set forth these individuals names, addresses, medical license numbers and any other information mutually agreed upon between the parties. This list shall be updated and maintained in a computerized format. FIG and FPIC agree that the membership database provided to FIG and FPIC by the FMA, pursuant to this Agreement constitutes FMA's confidential proprietary information. FMA represents that FMA Service shall have the authority to provide said list and updates thereto to FIG and FPIC in accordance with this Agreement. FIG and FPIC agree not to disclose any proprietary information obtained pursuant to this Agreement, directly or indirectly, or use it in any way, either during the course of this Agreement or at any later time, except as required in the course of this Agreement. All proprietary information, including all proprietary files, records, documents, and similar items relating to the business of the FMA, whether prepared by FMA or otherwise obtained by FIG or FPIC shall remain the exclusive property of FMA and shall not be used for any purposes other than those contained in this Agreement without the prior written consent of FMA.

J. Member Mailings. FMA shall implement at least two direct mail recruitment campaigns to FMA members. These mailings shall be implemented once in the spring and once in the fall. Both FMA and FPIC shall participate in determining the content, mechanics and scheduling of such mailings. Both FMA and FPIC shall share in the results of these mailings.

K. Quarterly Meetings of FMA & FPIC FMA and FPIC staff shall meet quarterly to communicate as needed to serve the intent and purpose of this Agreement.

L. Complaints Each party shall forward to the other within five (5) days of receipt, a copy of each and every written complaint, whether or not justified, received by the other party relating to or arising in any manner whatsoever from the operations of this Agreement or the consummation of the transactions contemplated by this Agreement. Each party agrees to keep all information provided confidential accept as provided by applicable law.

3. Term and Termination

A. Term. The term of this Agreement shall commence on the Effective Date and continue in effect for five (5) years.

B. Termination for Material Breach. Either party may terminate this Agreement upon thirty (30) days written notice to the other party in the event the other party breaches any of the material terms of this Agreement. The written notice shall specify, in detail, the facts or alleged facts surrounding the exact nature of the breach and the remedy requested. Once such written notice is provided, the breaching party may cure the breach during the thirty (30) day period, and in the event of such cure of the breach, to the reasonable satisfaction of the non-breaching party, this Agreement shall not be terminated.

C. Effect of Termination. FIG agrees that termination of this Agreement shall, in no way, excuse, FIG from any fees payable to FMA under this Agreement by FIG prior to the date this Agreement is terminated.

4. Special Terms of the Endorsement

A. Disclosure of Endorsement. During the term of this Agreement, the parties (and FPIC) shall have the right to disclose in any advertising, promotions, articles or other written, oral or electronic communications the fact that FPIC has been endorsed by FMA on an exclusive basis as a provider of professional liability insurance. Further, FMA shall grant to FIG and FPIC the use of the FMA name and logo to announce the availability of FPIC's programs as described in this Agreement in advertisements and in appropriate FMA member communications.

B. Other Endorsements By FMA This Agreement is exclusive. During the term of this Agreement, the FMA shall endorse FPIC as FMA's exclusive endorsed provider of professional liability insurance to FMA members.

C. Territory During the term of this Agreement, FIG and FPIC may use FMA's endorsement and logo without geographic restriction in accordance with this Agreement.

5. Miscellaneous Provisions

A. Use of Name and Logo FMA and FIG agree to use each others and each others subsidiaries and affiliate names and logos only in connection with the products/services described in this Agreement, and only when selling or marketing said product or service.

B. Assignment This Agreement is not assignable by either party without the other party's prior written consent.

C. Trademark "Trademarks" means any logo, servicemark, tradename or trademark personally used or acquired by FMA during the term of this Agreement. FMA warrants and represents that it has the right and power to license the Trademarks to FIG and FPIC for use as contemplated by this Agreement. FMA hereby grants FIG and FPIC a limited, nonexclusive license to use its Trademarks solely in conjunction with program, including the promotion thereof. This license shall be transferred upon assignment of this Agreement. This license shall terminate automatically upon the expiration or termination of this Agreement. Nothing stated in this Agreement prohibits FMA from granting to other persons a license to use the Trademark in conjunction with the provision of any other service or product.

D. Compliance with Law The parties agree that they shall perform their obligations hereunder according to all laws, rules, and regulations now or hereafter in effect applicable to them. If any term or provision of this Agreement is found to be illegal or unenforceable, this Agreement shall remain in full force and effect and such term or provision shall be considered stricken to the extent it is illegal or unenforceable.

E. Non-Waiver The parties agree that no waiver of any breach, privilege, or provision shall be construed as waiver of any future breach, privilege, or provision.

F. Authority to Contract The individuals executing this Agreement for the respective parties represent that they have full power and authority to enter into this Agreement and that it is binding.

G. Counterpart Signature This Agreement may be executed in any number of counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

H. Amendments. This Agreement may be modified or amended only in writing executed by both parties.

I. Governing Law. The validity, construction, and performance of this Agreement shall be governed and construed in accordance with the laws of the State of Florida. Any legal proceeding related to this Agreement shall be brought in a Florida state court located in the county of the defendant subject to Section 5(J) of this Agreement.

J. Mediation. The parties hereby agree to attempt to settle any and all disputes arising out of this Agreement through good faith attempts to settle such differences. Should any such disputes not be resolved through negotiation, both parties agree to submit such disputes to a certified court mediator in the county of the party's principal place of business that first serves notice to any other party to this Agreement of a desire to initiate mediation of a dispute prior to initiating any litigation. If a settlement is not reached within ninety (90) days of the submission of a case for mediation, either party may then initiate litigation related to such dispute.

K. Captions. The headings in this Agreement are for convenience only and do not affect the interpretation of this Agreement.

L. Entire Agreement. This Agreement constitutes the entire agreement between the parties hereto and supersedes all previous and contemporaneous oral and written negotiations, agreements, undertakings, or other commitments. No covenant or condition not expressed in this Agreement or incorporated herein by reference shall affect or be effective to interpret, change, or restrict this Agreement.

M. Notices. All notices and other communications required or permitted under this Agreement shall be in writing and shall be (i) hand-delivered, or (ii) sent by registered or certified first class mail, postage prepaid, or sent by nationally recognized express courier service. Such notices and other communications shall be effective upon receipt, and shall be sent to either party at the address below:

If to FIG or FPIC: Gary Izzo
Vice President of Marketing
First Professionals Insurance Company, Inc.
1000 Riverside Avenue, Suite 800
Jacksonville, Florida 32204

With a Copy to: Roberta Goes Cown, Esquire
Corporate Counsel
FPIC Insurance Group, Inc.
225 Water Street, Suite 1400
Jacksonville, Florida 32202

If to FMA: Sandra Mortham, Executive Vice President
Attention: Executive Vice President
Florida Medical Association. Inc.
113 East College Avenue
P.O. Box 10269
Tallahassee, FL 32301

N. No Third Party Rights Nothing in this Agreement, express or implied, is intended to confer upon any party, other than the parties hereto and their respective successors, legal representatives, and permitted assigns, any rights, remedies, obligations or liabilities under or by reason of this Agreement.

O. Confidentiality

(i.) Any material expressly deemed to constitute "confidential information" pursuant to this Agreement shall, unless indicated otherwise below, remain offered to the other parties for the sole purpose of fulfilling the terms of this Agreement, and may not be used for any other purpose or disclosed to any other party without the expressed written consent of the transmitting party.

(ii.) As used herein, the term "confidential information" shall mean all information that is transmitted to the other party relative this Agreement.

(iii.) Each party shall utilize any received confidential information only for the purposes described in this Agreement and, upon the termination of this Agreement, shall return to the transmitting party any and all copies of confidential information not needed for purposes of this Agreement.

(iv.) The party receiving confidential information hereunder shall be held to the same standard of care in protecting such information as the receiving party normally employs to preserve and safeguard its own confidential information of a similar kind.

P. Indemnification FIG on behalf of itself and its subsidiary FPIC hereby agrees to indemnify, defend, and hold FMA its members, officers, directors and employees harmless from any and all claims, losses, costs, expenses, damages, or liability suffered, incurred, or arising out of the rendition of FPIC's services or the provision of FPIC's products to FMA and its members.

FMA hereby agrees to indemnify, defend, and hold FIG and FPIC its officers, directors and employees harmless from any and all claims, losses, costs, expenses, damages, or liability suffered, incurred, or arising out of the rendition of FMA's duties as set forth in this Agreement.

Q. Relationship Nothing in this Agreement shall be deemed to constitute a joint venture, partnership, or agency between the parties. All employees of either FMA, FIG or FPIC shall be considered employees of their respective corporations and shall not be considered to be agents or employees of the other in any respect whatsoever.

IN WITNESS WHEREOF, the parties have executed this Agreement as of the Effective Date of this Agreement.

FPIC Insurance Group, Inc.

JRB

John R. Byers, President
FPIC Insurance Group, Inc.

6-13-02
Date

Florida Medical Association, Inc.

Sandra B. Mortham

Sandra B. Mortham
Executive Vice President

6-13-02
Date

SERVICES AGREEMENT

This Services Agreement (the "Agreement") is made this 1st day of July 2002, (the "Effective Date") between FPIC Insurance Group, Inc. (hereinafter referred to as "FIG"), a Florida corporation with a principal place of business at 225 Water Street, Suite 1400, Jacksonville, Florida 32202 and Flamedco, Inc. doing business as FMA Services, Inc. (herein after collectively referred to as "FMA Services"), a Florida not for profit corporation with a principal place of business at 113 East College Avenue, Tallahassee, Florida 32301.

WHEREAS, FIG provides medical professional liability insurance to physicians through its wholly owned subsidiary First Professionals Insurance Company, Inc. ("FPIC") and has entered into an Endorsement Agreement effective July 1, 2002 ("Endorsement Agreement") with the Florida Medical Association ("FMA") whereby the FMA has exclusively endorsed FPIC's medical professional liability insurance; and

WHEREAS, FMA desires to provide certain marketing services by and through FMA Services to promote FPIC's medical professional liability program in accordance with the Endorsement Agreement.

NOW, THEREFORE, and in consideration of the mutual covenants contained herein, the parties agree as follows:

1. Endorsement Agreement Definitions All terms defined in the Endorsement Agreement shall have the same meaning in this Agreement and are hereby incorporated by reference.

2. Quarterly Fees. During the term of this Agreement, FIG shall pay to FMA Services a fixed flat fee of ($5,000) five thousand dollars for services rendered by FMA Services as set forth in this Agreement on a calendar year quarterly basis, payable within ten (10) days after the end of each quarter. The first such payment shall be payable with respect to the quarter ending September 30, 2002.

3. Legislative Matters. In accordance with the Endorsement Agreement, during the term of this Agreement, FIG/FPIC shall assist FMA with respect to the monitoring of legislative matters. Notwithstanding any other provision, payments made pursuant to this Agreement shall not be made for the purpose of having FMA Services provide the types of activities described within Section 162(e) of the Internal Revenue Code, as amended in 1986, and/or the Regulations promulgated thereunder.

Original
Contract

Services Agreement FIG/FMA Services

4. FMA Publications. In accordance with the Endorsement Agreement, the creation, distribution and approval of any advertising or promotion of the Program or FPIC as mentioned in Section 2(D) of the Endorsement Agreement shall be coordinated through and performed by FMA Services. The value related to this advertising shall be included as part of the fees FIG shall pay to FMA Services as set forth in Section 2 of this Agreement.

5. Web Page Linkage. In accordance with Section 2(G) of the Endorsement Agreement, FMA Services and FIG shall establish and maintain links between FMA's and FIG's Internet web sites.

6. Marketing In accordance with Section 2(H) of the Endorsement Agreement, Membership mailings and/or placement and approval of articles in FMA periodicals and other media shall be coordinated through and performed by FMA Services.

7. List Development and Maintenance. In accordance with Section 2(I) of the Endorsement Agreement, FMA shall make available to FPIC a list of FMA members and non-member physicians (practicing in the state of Florida), which shall set forth these individuals names, addresses, medical license numbers and any other information mutually agreed upon between the parties. FMA Services shall update and maintain this computerized list and coordinate the dissemination of the same to FIG and FPIC. FIG and FPIC reiterate and reconfirm their agreement that the membership database provided to FIG and FPIC by the FMA (pursuant to the Endorsement Agreement) by and through FMA Services constitutes FMA's confidential proprietary information. FIG and FPIC agree not to disclose any proprietary information obtained pursuant to this Agreement, directly or indirectly, or use it in any way, either during the course of this Agreement or at any later time, except as required in the course of the Endorsement Agreement.

8. Member Mailings. In accordance with Section 2(J) of the Endorsement Agreement, all Membership mailings shall be coordinated through and performed by FMA Services.

9. Complaints Each party shall forward to the other within five (5) days of receipt, a copy of each and every written complaint, whether or not justified, received by the other party relating to or arising in any manner whatsoever from the operations of this Agreement or the consummation of the transactions contemplated by this Agreement. Each party agrees to keep all information provided confidential except as provided by applicable law.

Services Agreement FIG/FMA Services

10. Term & Termination The term of this Agreement shall commence on the Effective Date. This Agreement shall automatically terminate at the same date and time of the termination of the Endorsement Agreement. This Agreement shall also automatically renew upon any renewal of the Endorsement Agreement, for the same period of time for which the Endorsement Agreement is renewed. FIG agrees that termination of this Agreement shall, in no way, excuse, FIG from any fees payable to FMA Services under this Agreement by FIG prior to the date this Agreement is terminated.

11. Assignment This Agreement is not assignable by either party without the other party's prior written consent.

12. Compliance with Law The parties agree that they shall perform their obligations hereunder according to all laws, rules, and regulations now or hereafter in effect applicable to them. If any term or provision of this Agreement is found to be illegal or unenforceable, this Agreement shall remain in full force and effect and such term or provision shall be considered stricken to the extent it is illegal or unenforceable.

13. Non-Waiver The parties agree that no waiver of any breach, privilege, or provision shall be construed as waiver of any future breach, privilege, or provision.

14. Authority to Contract The individuals executing this Agreement for the respective parties represent that they have full power and authority to enter into this Agreement and that it is binding.

15. Counterpart Signature This Agreement may be executed in any number of counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

16. Amendments. This Agreement may be modified or amended only in writing executed by both parties.

17. Governing Law. The validity, construction, and performance of this Agreement shall be governed and construed in accordance with the laws of the State of Florida. Any legal proceeding related to this Agreement shall be brought in a Florida state court located in the county of the defendant subject to Section 18 of this Agreement.

18. Mediation. The parties hereby agree to attempt to settle any and all disputes arising out of this Agreement through good faith attempts to settle such differences. Should any such disputes not be resolved through negotiation, both parties agree to submit such disputes to a certified court mediator in the county of the party's principal place of business that first serves notice to any other party to this Agreement of a desire to initiate mediation of a dispute prior to initiating any litigation. If a settlement is not reached within ninety (90) days of the submission of a case for mediation, either party may then initiate litigation related to such dispute.

Services Agreement FIG/FMA Services

19. Captions. The headings in this Agreement are for convenience only and do not affect the interpretation of this Agreement.

20. Entire Agreement. This Agreement constitutes the entire agreement between the parties hereto and supersedes all previous and contemporaneous oral and written negotiations, agreements, undertakings, or other commitments. No covenant or condition not expressed in this Agreement or incorporated herein by reference shall affect or be effective to interpret, change, or restrict this Agreement.

21. Notices. All notices and other communications required or permitted under this Agreement shall be in writing and shall be (i) hand-delivered, or (ii) sent by registered or certified first class mail, postage prepaid, or sent by nationally recognized express courier service. Such notices and other communications shall be effective upon receipt, and shall be sent to either party at the address below:

If to FIG: Gary Izzo
Vice President of Marketing
First Professionals Insurance Company, Inc.
1000 Riverside Avenue, Suite 800
Jacksonville, Florida 32204

With a Copy to: Roberta Goes Cown, Esquire
Corporate Counsel
FPIC Insurance Group, Inc.
225 Water Street, Suite 1400
Jacksonville, Florida 32202

If to FMA: Sandra Mortham, Executive Vice President
Attention: Executive Vice President
Florida Medical Association. Inc.
113 East College Avenue
P.O. Box 10269
Tallahassee, FL 32301

22. No Third Party Rights Nothing in this Agreement, express or implied, is intended to confer upon any party, other than the parties hereto and their respective successors, legal representatives, and permitted assigns, any rights, remedies, obligations or liabilities under or by reason of this Agreement.

Services Agreement FIG/FMA Services

23. Confidentiality

(i.) Any material expressly deemed to constitute "confidential information" pursuant to this Agreement shall, unless indicated otherwise below, remain offered to the other parties for the sole purpose of fulfilling the terms of this Agreement, and may not be used for any other purpose or disclosed to any other party without the expressed written consent of the transmitting party.

(ii.) As used herein, the term "confidential information" shall mean all information that is transmitted to the other party relative this Agreement.

(iii.) Each party shall utilize any received confidential information only for the purposes described in this Agreement and, upon the termination of this Agreement, shall return to the transmitting party any and all copies of confidential information not needed for purposes of this Agreement.

(iv.) The party receiving confidential information hereunder shall be held to the same standard of care in protecting such information as the receiving party normally employs to preserve and safeguard its own confidential information of a similar kind.

24. Indemnification FIG on behalf of itself and its subsidiary FPIC hereby agrees to indemnify, defend, and hold FMA Services its members, officers, directors and employees harmless from any and all claims, losses, costs, expenses, damages, or liability suffered, incurred, or arising out of the rendition of FPIC's services or the provision of FPIC's products to FMA and its members.

FMA Services hereby agrees to indemnify, defend, and hold FIG and FPIC its officers, directors and employees harmless from any and all claims, losses, costs, expenses, damages, or liability suffered, incurred, or arising out of the rendition of FMA Services' duties as set forth in this Agreement.

25. Relationship Nothing in this Agreement shall be deemed to constitute a joint venture, partnership, or agency between the parties. All employees of either FMA Services, FIG or FPIC shall be considered employees of their respective corporations and shall not be considered to be agents or employees of the other in any respect whatsoever.

[Signatures On Next Page]

Services Agreement FIG/FMA Services

IN WITNESS WHEREOF, the parties have executed this Agreement as of the Effective Date of this Agreement.

FPIC Insurance Group, Inc.

John R. Byers, President
FPIC Insurance Group, Inc.

6-13-02
Date

Flamedco, Inc. d.b.a. FMA Services, Inc.

Sandra B. Mortham
President

6-13-02
Date

Business Wire

FPIC Insurance Group, Inc. Reports Extension of Exclusive FMA Endorsement

June 13, 2002 2:17:00 PM ET

JACKSONVILLE, Fla.--(BUSINESS WIRE)--June 13, 2002--FPIC Insurance Group, Inc. (the "Company") FPIC today reported that its exclusive endorsement by the Florida Medical Association ("FMA") has been extended for an additional five years through June 30, 2007.

John R. Byers, President and Chief Executive Officer, stated, "We are excited about our continued endorsement by the FMA for an additional five years. The FMA is the largest organization representing interests of Florida physicians and their patients. Our long-standing relationship with the FMA is one of the reasons for our success and keeps us aligned with the needs and goals of our policyholders and the medical community at large."

Safe Harbor Disclosure

The Private Securities Litigation Reform Act of 1995 provides a "safe harbor" for forward-looking statements. Any written or oral statements made by or on behalf of the Company may include forward-looking statements, which reflect the Company's current views with respect to future events and financial performance. These forward-looking statements are subject to certain uncertainties and other factors that could cause actual results to differ materially from such statements. These uncertainties and other factors (which are described in more detail in documents filed by the Company with the Securities and Exchange Commission) include, but are not limited to, (i) uncertainties relating to government and regulatory policies (such as subjecting the Company to insurance regulation or taxation in additional jurisdictions or amending, revoking or enacting any laws, regulations or treaties affecting the Company's current operations), (ii) the occurrence of insured or reinsured events with a frequency or severity exceeding the Company's estimates, (iii) legal developments, (iv) the uncertainties of the loss reserving process, (v) the actual amount of new and renewal business and market acceptance of expansion plans, (vi) the loss of the services of any of the Company's executive officers, (vii) changing

rates of inflation and other economic conditions, (viii) the ability to collect reinsurance recoverables, (ix) the competitive environment in which the Company operates, related trends and associated pricing pressures and developments, (x) the impact of mergers and acquisitions, including the ability to successfully integrate acquired businesses and achieve cost savings, competing demands for the Company's capital and the risk of undisclosed liabilities, (xi) developments in global financial markets that could affect the Company's investment portfolio and financing plans, (xii) risk factors associated with financing and refinancing, including the willingness of credit institutions to provide financing and the availability of credit generally, (xiii) developments in reinsurance markets that could affect the Company's reinsurance program; and (xiv) changes in the Company's financial ratings resulting from one or more of these uncertainties and other factors.

The words "believe," "anticipate," "foresee," "estimate," "project," "plan," "expect," "intend," "hope," "should," "will likely result" or "will continue" and variations thereof or similar expressions identify forward-looking statements. Readers are cautioned not to place undue reliance on these forward-looking statements, which speak only as of their dates. The Company undertakes no obligation to publicly update or revise any forward-looking statements, whether as a result of new information, future events or otherwise.

Corporate Profile

FPIC Insurance Group, Inc., through its subsidiary companies, is a leading provider of professional liability insurance for physicians, dentists, other healthcare providers and attorneys, primarily in Florida and Missouri. In addition, the Company provides reciprocal management and administration services to Physicians' Reciprocal Insurers, the second largest medical professional liability insurance carrier in the state of New York, and third party administration services both within and outside the healthcare industry. Its insurance subsidiaries, First Professionals Insurance Company, Inc., Anesthesiologists Professional Assurance Company, Intermed Insurance Company and Interlex Insurance Company, have an A- (Excellent) group rating from A.M. Best.

For all your investor needs, FPIC is on the Internet at http://www.fpic.com . Got a Tough Question? E-mail us at ir@FPIC.com . FPIC: Providing Answers in a Changing Market.

Contact Information:
FPIC Insurance Group, Inc., Jacksonville
Kim D. Thorpe, 904/354-2482, Extension 3287
or
Roberta Goes Cown, 904/354-2482, Extension 3287

ENDORSEMENT AGREEMENT

This Agreement made this 27th day of July 1999, by and between THE FLORIDA MEDICAL ASSOCIATION, INC. (hereinafter referred to as "FMA") and FLORIDA PHYSICIANS INSURANCE COMPANY, INC. (hereinafter referred to as "FPIC").

WHEREAS, FMA offers products and services to physician members in Florida; and

WHEREAS, FPIC, which is a subsidiary of FPIC Insurance Group, Inc., is a Florida insurance company and writes professional liability insurance and provides other insurance related products and services for physicians;

WHEREAS, FPIC desires for FMA to endorse FPIC on an exclusive basis as a provider of professional liability insurance and health insurance and FMA wishes to so endorse FPIC; and

WHEREAS, FMA and FPIC desire to enter into a contract providing for endorsement of FPIC and FPIC's programs as described in this Agreement on the terms and conditions herein set forth.

NOW, THEREFORE, and in consideration of the mutual covenants contained herein, the parties agree as follows:

ARTICLE 1 - DEFINITIONS

1. "Customer" means any Member who is a participant in the Program.
2. "Mailing lists" means updated and current lists, electronic media (in a format agreeable to both FPIC and FMA) and/or labels containing names, postal addresses and telephone numbers of Members segmented by zip codes or reasonably selected membership characteristics.
3. "Member" means any member of the FMA, plus other individuals mutually agreed upon by both FMA and FPIC.
4. "Program" means the products/services offered by FPIC to Members as described in this Agreement.
5. "Trademarks" means any logo, servicemark, tradename or trademark personally used or acquired by FMA during the term of this Agreement.

ARTICLE 2 – FMA DUTIES

A. During the term of this Agreement, FMA shall:

1. Endorse FPIC as FMA's exclusive endorsed provider of professional liability insurance and health insurance for FMA members.

2. Provide FPIC the use of the FMA name and logo to announce the availability of FPIC's programs as described in this Agreement in appropriate FMA member communications.

3. Provide FPIC. on a quarterly basis. with current and updated mailing lists (or electronic media) of FMA members and nonmembers, when available, free of charge.

4. Permit a representative of FPIC to attend at least one meeting of the FMA Board of Governors annually.

5. Provide FPIC, free of charge, highest level corporate sponsorship exhibit space at each FMA annual and district meeting, if applicable.

B. During the term of this Agreement, FMA agrees that:

1. FMA, including its officers, directors and staff, shall endorse and actively promote the sale of FPIC's products/services as described in this Agreement to its membership through membership mailings and/or articles in FMA periodicals and other media, as FMA and FPIC jointly agree. FMA agrees to direct FMA member inquiries regarding the product/service to FPIC.

2. FMA and FPIC shall jointly develop a marketing committee that shall be comprised of three representatives designated by FMA's Board of Governors and three representatives designated by FPIC to develop annual joint marketing plans with respect to programs and goals.

3. During the term of this Agreement, FMA shall not permit any advertising or promotion in FMA periodicals or FMA meetings of any professional liability insurance or health insurance offered by any other insurance carrier.

ARTICLE 3 – FPIC'S DUTIES

A. During the term of this Agreement, FPIC shall:

1. Use FMA's seal on FPIC promotional materials, as appropriate, while FPIC is endorsed by FMA. Upon expiration or revocation of the FMA endorsement of FPIC, FPIC agrees to stop using and return the seal.

2. Benefits to FMA.

(a) Quarterly Compensation. During the term of this Agreement, FPIC shall pay to FMA $125,000 quarterly, payable within ten (10) days after the end of each calendar quarter. The first such payment shall be payable with respect to the quarter ending June 30, 1999.

(b) Additional Compensation. During the term of this Agreement and as long as FPIC's health insurance program for FMA members remains in place, FPIC shall pay to FMA $62,500 quarterly, payable within ten (10) days after the end of each calendar quarter. The first such payment shall be payable with respect to the quarter ending June 30, 1999. In the event that 3% of the written premiums for a calendar quarter during the

term of this Agreement received by FPIC from FMA members for health insurance under FPIC's health insurance program for FMA members exceeds $250,000, FPIC shall pay FMA within 45 days after the end of such year the amount by which 3% of such premium exceeds $250,000.

(c) Revenues of Certain Affiliates. FPIC shall pay to FMA within thirty (30) days after the end of each calendar quarter during the term of this Agreement, commencing with the quarter ending June 30, 1999, an amount equal to three (3) percent of the revenues collected during such quarter by Professional Strategy Options, Inc. and by the Florida division of Bexar Credentials Verification, Inc.

(d) Contributions. During 1999. FPIC shall contribute a total of $50,000 to be distributed evenly between Kay Hanley, M.D. and Cecil Wilson, M.D. in connection with their campaigns for election to American Medical Association offices.

(e) Risk Management Program. FPIC will continue to work with FMA during the term of this Agreement to develop a risk management program that wil provide continuing medical education credits for FMA members.

(f) Legislative Matters. During the term of this Agreement, FPIC shall assist FMA with respect to legislative matters to the extent practicable to do so.

3. Forward to FMA, within thirty (30) days of receipt, a copy of each and every written complaint, whether or not justified, received by FPIC relating to or arising in any manner whatsoever from the operations of this Agreement or the consummation of the transactions contemplated by this Agreement. FMA agrees to keep all information provided confidential consistent with FPIC's confidentiality obligations to its clients.

B. During the term of this Agreement, FPIC agrees that:

1. FPIC is primarily responsible for marketing the products and/or services described in this Agreement and agrees to offer the Program to the Members and to directly compensate FMA with revenues generated thereby, and FMA agrees to endorse the Program and provide FPIC with information, licenses and general assistance for solicitation and administration of Program to Members.

2. All mailings and promotional campaigns are to be at the expense of FPIC and FPIC shall design all advertising solicitation and promotional materials with regard to the Program.

3. FMA shall have the right of prior approval of all program advertising and solicitation materials to be used by FPIC which contain either FMA's trademark or the endorsement of FMA.

4. FPIC shall provide FMA no later than 30 days from the date of this Agreement a toll-

free telephone number and the name of a contact person for which to refer FMA member inquiries.

5. FPIC agrees that the membership database provided to FPIC by FMA pursuant to this Agreement constitutes confidential proprietary information. FPIC agrees not to disclose any proprietary information obtained pursuant to this Agreement, directly or indirectly, or use it in any way, either during the course of this Agreement or at any later time, except as required in the course of this Agreement. All proprietary information, including all proprietary files, records, documents, and similar items relating to the business of the FMA, whether prepared by FMA or otherwise obtained by FPIC shall remain the exclusive property of FMA and shall not be used for any purposes other than those contained in this Agreement without the prior written consent of FMA.

6. FMA may exercise due diligence and periodic reviews of FPIC's program to ensure quality standards for its participation.

7. FMA's endorsement to its members of FPIC's products/services is based in good faith on FPIC's representations concerning the products/services and FMA has neither inspected nor utilized the products/services.

8. FPIC may submit articles pertaining to professional liability insurance in camera-ready form for publication in FMA periodicals as long as such articles are submitted reasonably ahead of publication and are approved by the FMA.

ARTICLE 4 – TERMINATION

A. The term of this Agreement shall commence on the effective date and continue in effect for three (3) years.

B. The FMA may terminate this Agreement upon thirty (30) days written notice to FPIC in the event FPIC ceases paying FMA the additional compensation from FPIC's health insurance program described in Article 3.A.2(b) of this Agreement

C. Either party may terminate this Agreement upon thirty (30) days written notice to the other party in the event the other party breaches any of the material terms of this Agreement. The written notice shall specify the event of the breach. Once such written notice is provided, the breaching party may cure the breach during the thirty (30) day period, and in the event of such cure of the breach, to the reasonable satisfaction of the non-breaching party, this Agreement shall not be terminated.

D. FPIC agrees that termination of this Agreement shall, in no way, excuse FPIC from any compensation payable to FMA under this Agreement by FPIC prior to the date this Agreement is terminated.

ARTICLE 5 – INDEMNIFICATION

FPIC hereby agrees to indemnify, defend, and hold FMA, its members, officers, directors, and employees harmless from any and all claims, losses, costs, expenses, damages, or liability suffered, incurred, or arising out of the rendition of FPIC's services or the provision of FPIC's products to FMA and its members.

ARTICLE 6 – DISCLOSURE OF ENDORSEMENT

During the term of this Agreement, the parties shall have the right to disclose in any advertising, promotions, articles or other written, oral or electronic communications the fact that FPIC has been endorsed by FMA on an exclusive basis as a provider of professional liability and health insurance.

ARTICLE 7 – OTHER ENDORSEMENTS BY FMA

This Agreement is exclusive. During the term of this Agreement, the FMA shall endorse FPIC as FMA's exclusive endorsed provider of professional liability and health insurance to FMA members.

ARTICLE 8 – TERRITORY

FPIC may use FMA's endorsement and logo without geographic restriction, outside the state of Florida provided, however, FPIC receives FMA's prior written approval.

ARTICLE 9 – AGENCY

Nothing in this Agreement shall be deemed to constitute a joint venture, partnership, or agency between the parties. All employees of either the FMA or FPIC shall be considered employees of their respective corporations and shall not be considered to be agents or employees of the other in any respect whatsoever.

ARTICLE 10 – ENTIRE AGREEMENT

This Agreement constitutes the entire agreement between the parties concerning the subject matter herein and all prior representations, statements, negotiations and undertakings are superseded or restated herein.

ARTICLE 11 – AMENDMENTS

No amendment to this Agreement shall be effected unless it is in writing and signed by the authorized corporate officers of both parties.

ARTICLE 12 – GOVERNING LAW

This Agreement shall be governed by and construed according to the laws of the State of Florida.

ARTICLE 13 – MISCELLANEOUS PROVISIONS

A. Both FMA and FPIC agree to use each others' names and logos only in connection with the products/services described in this Agreement, and only when selling or marketing said product or service to physicians.

B. This Agreement is not assignable by either party without the other party's prior written consent, which consent shall not be unreasonably withheld.

C. FMA warrants and represents that it has the right and power to license the Trademarks to FPIC for use as contemplated by this Agreement. FMA hereby grants FPIC a limited, nonexclusive license to use its Trademarks solely in conjunction with program, including the promotion thereof. This license shall be transferred upon assignment (as provided in Article 13. B.) of this Agreement. This license shall terminate automatically upon the expiration or termination of this Agreement. Nothing stated in this Agreement prohibits FMA from granting to other persons a license to use the Trademark in conjunction with the provision of any other service or product.

D. Both parties agree that they shall perform their obligations hereunder according to all laws, rules, and regulations now or hereafter in effect applicable to them. If any term or provision of this Agreement is found to be illegal or unenforceable, this Agreement shall remain in full force and effect and such term or provision shall be considered stricken to the extent it is illegal or unenforceable.

E. The parties agree that no waiver of any breach, privilege, or provision shall be construed as waiver of any future breach, privilege or provision.

F. The individuals executing this Agreement for the respective parties represent that they have full power and authority to enter into this Agreement and that it is binding.

G. This Agreement may be executed in any number of counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

ARTICLE 14 - NOTICE

Any notice hereunder shall be written and mailed by certified or registered mail, return receipt requested, reputable overnight courier, or hand delivered at the following addresses:

FLORIDA MEDICAL ASSOCIATION:

Florida Medical Association, Inc.
113 East College Avenue
P.O. Box 10269
Tallahassee, FL 32301

Attn: Executive Vice President
Telephone: (850) 224-6496
Facsimile: (850) 222-8030

FPIC:

Florida Physicians Insurance Company, Inc.
1000 Riverside Avenue
Suite 800
Jacksonville, FL 32204
Attn: President
Telephone: (904) 354-5910
Facsimile: (904) 358-9184

or to such other addresses with respect to a party as such party may specify from time to time by notice given as provided herein.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the day, month, and year written above.

Florida Medical Association

Donald F. Foy, Sr.
Executive Vice President

Florida Physicians Insurance Company, Inc.

Steven Smith
President

First Professionals Insurance Company's

Written Presentation To

Governor's Select Task Force on Healthcare Professional Liability Insurance

By: Robert E. White, Jr.
Executive Vice President and Chief Operating Officer

Orlando, Florida

October 21, 2002

About First Professionals

First Professionals Insurance Company has served the Florida medical professional liability market for 27 years. Formerly known as Florida Physicians Insurance Company, the company is the market leader in the state, insuring over 6,000 Florida doctors and 2,500 Florida dentists. It is one of only two carriers writing the medical professional liability line that remains domiciled in Florida. The other Florida domiciled company is Anesthesiologists Professional Assurance Company, which is owned by the same publicly traded holding company that owns our company.

The Same Crisis

Our appearance before you today is occasioned by another outbreak in a struggle that has plagued Florida doctors since 1975. Some observers have termed this the "third medical professional liability insurance crisis." It is our position that this is not the third crisis but rather, it is the same crisis that has existed since 1975. Like an illness that remains undiagnosed and untreated, it's symptoms will flair up from time to time. The availability and affordability of professional liability insurance for physicians is not the illness you have been asked to diagnose and cure, they are only symptoms of a much more serious illness. This illness is Florida's liberal tort system.

Various groups have studied this illness since 1975. The cures your predecessors recommended in the past only treated the symptoms of the condition and never the illness that produced the symptoms. Like any illness that remains undiagnosed and untreated, it becomes much more difficult to cure as time passes. Now, 27 years after the first onset of symptoms, you have been asked to save the patient. Make no mistake about the patient's identity. It is not physicians, nor attorneys nor insurance companies. The patient is all of the citizens of Florida and their right and ability to access medical care.

Availability and Affordability Only Symptoms

1975 was the first year that actuaries told the insurance industry that they could no longer guarantee that the rates they were recommending be charged today for medical professional liability insurance would be enough to pay tomorrow's claims. That is the first time the symptoms of availability and affordability presented themselves. Many changes were made to Florida's tort system, a Patients Compensation Fund was created and doctor owned insurance companies were formed. These changes made the symptoms temporarily abate. When the symptoms reappeared in 1983, they lasted for five years. They were abated by a combination of legislative changes to Florida's tort system and by the doctors themselves. Physicians, who were enjoying incomes that were higher than at any time in the history of our country, absorbed the increased cost or passed it on. Once again, the symptoms disappeared. Now they are back again. This time is different. This time they will not go away without intensive therapy.

Things are different now. Doctors are no longer able to pass the increased costs for professional liability insurance along to their patients because of the prevalence of managed care. Government reimbursed compensation of patient care is not only not increasing to cover increased costs, but is actually being reduced from present levels.

Physician incomes are falling and their expenses are rising. Doctors find themselves in an impossible dilemma. Some will retire, some will leave the state and many will decide to practice without professional liability insurance. Bare physicians, of necessity, will no longer perform all of the procedures they did when they carried insurance. They will carefully screen their patients. All of these things combined will have a negative impact on the ability of Floridians to access medical care in the immediate future unless effective action is taken.

Start With Academic Task Force 1987 Report

The Academic Task Force for Review of Insurance and Tort Systems, which studied the problem for two years, has already addressed many of the same issues that confront you today. That task force has already debunked many of the myths associated with these controversial issues. Arguments about bad doctors, greedy lawyers, greedy insurance companies and bad management have already been thoroughly addressed. We strongly recommend that you start where they left off.

We believe that you will conclude, like the Academic Task Force did in 1987, that the primary cause of price increases in medical professional liability premiums is the substantial increase in loss payments to claimants[1]. We also believe that you will conclude as they did that the profitability of insurance companies is not an issue. They found that as an industry, insurance companies are slightly less profitable than the average American industrial or financial sectors of our economy[2]. We believe that you will also find that the underwriting cycle is ultimately driven by increases in loss costs more than any other single factor[3].

Where your findings may differ from theirs is in the area of average indemnity payments. The Academic Task Force found that the average cost of paid claims increased at a compound rate of 14.8% between 1975 and 1987[4]. They felt this increase in the average severity of claims was a more important factor than the frequency of indemnity payments.

One of the factors that caused the dramatic growth in the average indemnity payment during the period the Academic Task Force studied was the Patients Compensation Fund. The Fund provided coverage for Florida physicians from 1975 to July of 1983. Doctors who joined the Fund had unlimited liability coverage. When the Fund went out of business and insurance became more expensive, the only way doctors could control the cost of insurance was to limit the amount of coverage they bought. Since 1985, approximately half of all physicians in Florida buying insurance purchase $250,000 per claim limits. This low limit of coverage acts as a restraining factor on the average indemnity paid. This is particularly true when you compare it to the period in which most physicians were Fund members and had no limit of liability.

[1] *Academic Task Force for Review of Insurance and Tort System, Preliminary Fact Finding Report, Executive Summary, Page 4, Item 3, August 6, 1987.*
[2] *Id. Item 4.*
[3] *Id. Item 6.*
[4] *Id. Item 9.*

The Problem Is Liberal Court System Not Bad Doctors

Bad doctors are not the cause of the problem. Doctors are better trained and more able to successfully treat their patients than at any time in history. There is no better system of healthcare anywhere in the world. What has changed is that doctors have more potent pharmaceutical agents than ever before. They are surrounded by technology, used in diagnosing and treating patients, more advanced than ever before. Even when used correctly, these pharmaceutical agents and the technology used to diagnose and treat patients can cause outcomes that are at times worse than the condition being treated or diagnosed. Patients are suing more often when these bad outcomes occur, even though they are not the fault of the physician.

These are complex cases and juries must listen to expert testimony that always conflicts due to the extensive use of expert witnesses. These cases usually involve very serious injuries. Even though jurors are required to promise that they will not let sympathy, passion or prejudice influence their decision, often times that is the only way one can explain the outcomes. Now that jury pools are drawn from licensed drivers, the outcomes of medical malpractice trials have become even more difficult to predict and awards are skyrocketing. Florida's appellate courts are renown for their liberality and are reluctant to overturn jury verdicts for the plaintiff.

Liberal Courts Cause Increasing Loss Costs

It is our position that loss costs are driving the price increases that have brought this problem to the forefront, again. As demonstrated by Table 1 below, what we have to show for 27 years of effort in trying to resolve this issue is a problem that is 3,074% worse than when we started.

Table 1. **Payouts**

Year	*Number of Payments*	*Indemnity Paid*	*Average*
1975	390[1]	$10,271,910[1]	$26,338
2001	1,303[2]	$326,052,228[2]	$250,232
% Increase	234%	3,074%	850%

[1] Florida Department of Insurance
[2] National Practitioner's Data Bank

It is the total indemnity payout that is presently driving the dramatic rate increases in medical professional liability insurance. The level of these payments has reached these unprecedented heights because physicians and their insurers no longer have faith in the predictability or fairness of Florida's court system. As you can see from Table 2 below, from 1999 to 2001 the total indemnity paid to resolve medical professional liability cases in Florida increased $81,110,076, or 33.1%, according to data from the National Practitioners Data Bank.

Table 2. **Florida Indemnity Payments**

Year	*Number of Payments*	*Indemnity Paid*
1999	1,053	$244,942,152
2000	1,228	$319,706,647
2001	1,303	$326,052,228

The total indemnity payout is driven by the fact that Florida physicians and their insurers are forced to settle cases much more frequently than physicians in other states. The Physician Insurers Association of America (PIAA) data sharing program reports that nationwide 30% of all claims brought against physicians result in an indemnity payment. Florida physicians settle more than 50% of the cases brought against them according to data from the Florida Department of Insurance. On June 24, 2002, American Physicians Capital, formerly an active carrier in the Florida medical professional liability market, cited Florida's unpredictable and unfavorable legal climate as the reason it could not write business profitably when it announced it was going to stop writing business in Florida.

The dramatic difference between Florida and the national average for the frequency of indemnity payments is due to the uncertainty Florida physicians face in going to court. Doctors face the prospect of financial ruin if they lose in court. Most of them carry $250,000 limits and, as a result, are grossly underinsured by both national and regional standards. The most prevalent limit sold to physicians in the United States is $1,000,000 per claim. In the southern United States most physicians carry multi-million dollar per claim limits. In short, the average medical malpractice jury verdict in Florida far exceeds the limits most Florida doctors carry.

Another factor related to the frequency of indemnity payments is Florida's onerous and subjective bad faith laws. These laws, both statutory and case law, can result in insurance carriers being responsible for the entire verdict when a jury returns a verdict in excess of the doctor's per claims policy limit. This makes the insurance carrier think long and hard before trying any case in Florida and dramatically drives up costs.

There is ample evidence to demonstrate that indemnity payments are being made more frequently in Florida. The Academic Task Force found that claims payments were increasing at a rate of 4.6% per year but only 1.8% when adjusted for population increases[5]. Using data from the National Practitioners Data Bank regarding the number of indemnity payments annually, our actuary has determined the growth rate in the frequency of indemnity payments in Florida has been 4.9% per year from 1986 through 2001, 2.5% when adjusted for population growth. See Table 3 below.

[5] *Id. Item 8.*

Table 3. **Growth Rate in Cases Closed with Indemnity Paid Adjusted for Population Growth***

Years	*Growth Rate*
1975 - 1986	1.80%
1986 - 2001	2.50%

* Population data from U.S. Census Bureau, U.S. Department of Commerce Census 2000; claims data from Florida Department of Insurance closed claim reports.

By comparing 1987 Florida Department of Insurance data with 2001 National Practitioner Data Bank data, our actuary has determined that average claims severity has been increasing at a rate of 5.2% per year in Florida. Since loss cost trends are a combination of frequency and severity, one must apply the increase shown in Table 3 to the 5.2% increase in average severity to measure the total impact increasing severity has on loss costs. This calculation shows that loss costs have increased 7.9% per year since 1987. These loss costs are the primary reason premiums are so high in Florida. Table 4 below shows the average annual premium increase since 1983 for certain specialties.

Table 4. **Premium Comparison* July 1, 1983 to July 1, 2002**

Dade County

Specialty	*7/1/1983*[1]	*7/1/2002*[2]	*Average Annual Increase*
Family Practice-No Surgery	$4,310	$52,300	14.0%
Internal Medicine-Minor Surgery	$7,825	$52,380	10.5%
Emergency Room	$9,777	$96,800	12.8%
General Surgery	$21,971	$174,300	11.5%
Orthopedic Surgery	$27,073	$183,949	10.6%
Obstetrics	$30,433	$201,376	10.4%
Neurosurgery	$37,569	$278,829	11.1%

Rest of State

Specialty	*7/1/1983*[1]	*7/1/2002*[2]	*Average Annual Increase*
Family Practice-No Surgery	$3,123	$26,810	12.0%
Internal Medicine-Minor Surgery	$5,606	$26,810	8.6%
Emergency Room	$6,992	$49,649	10.9%
General Surgery	$15,705	$89,368	9.6%
Orthopedic Surgery	$19,355	$94,333	8.7%
Obstetrics	$21,679	$103,270	8.6%
Neurosurgery	$27,285	$142,989	9.1%

[1] Weighted average of FPIC, PPTF, St. Paul rates taken from the Academic Task Force for Review

[2] FPIC Rate

*$1 million per claim / $3 million annual aggregate limit

Capping Non-Economic Damages Key to Rate Stability

There is but one cure for what ails Florida's tort system and that is an absolute cap on non-economic damages. An absolute cap on non-economic damages is the only thing that can make jury verdicts more predictable and predictability of loss costs is the only thing that will stabilize insurance premiums. Unfortunately, although such a cap is in place in a number of jurisdictions, that cure is not yours to give. In 1987 our Supreme Court ruled in *Smith v. Department of Insurance* that a $450,000 cap on non-economic damages was unconstitutional.

The Academic Task Force knew this and adopted a system that would make a cap on non-economic damages conditional upon an offer to admit liability and arbitrate the case on damages only. Their approach capped non-economic damages at $250,000 if arbitration was accepted and $350,000 if it was not accepted and the case proceeded through the court system. This concept was found to be constitutional by our Supreme Court in 1993 in *University of Miami, Etc. v. Escharte*. Unfortunately, in 1997, the Supreme Court ruled in *St. Mary's v. Phillipe* that the caps on non-economic damages applied per claimant and not per case as the Academic Task Force intended. So in a case of the wrongful death of a spouse, the cap on the case brought by a surviving spouse with two minor children would be $250,000 times three or $750,000. The Supreme Court also ruled in *Franzen v. Mogler* that claimants who agree to arbitrate in wrongful death cases are allowed to recover damages that they are not entitled to recover under Florida's wrongful death statute. This decision had the effect of making most wrongful death cases, which constitute 25% of all of the medical malpractice cases insurers are presented with, worth two or three times more in arbitration than if the case went to court without a cap.

The *St. Mary's* and *Franzen* decisions introduced so much uncertainty associated with the offer of arbitration vehicle the Academic Task Force created that insurers are no longer willing to risk using it. We strongly urge you to recommend that the legislature correct the technical flaws that the Supreme Court cited in their decisions so that we can use this mechanism in claims handling. It had a positive impact when it was being used as it promoted predictability in damage awards. Predictability has a positive impact on ratemaking and will help to stabilize premiums. Predictability also promotes settlements as it eliminates the area of contention over what a jury might do on the non-economic aspect of a claim.

Bad Management-Red Herring

The insurance industry has been criticized for bad management and is being blamed for causing the current situation. Some people feel we kept our prices too low for too long. To understand why this is not true, one needs to understand that in 1975 most of the commercial insurance industry walked away from the medical professional liability line of business. Physicians in most states created their own insurance companies and these companies filled the niche. In 1995, when investment returns soared, many of the commercial carriers who walked away started to reenter the marketplace. Many of the small doctor owned companies began to expand into new states as a way of maintaining

market share. They were particularly attracted to Florida because of its very high premiums per risk.

At that time in Florida we had over 40 companies writing this line of business. Some of the companies that came into the state in the 1990's were charging rates that were 40 to 60% below the rates charged by the carriers domiciled in the state. The demand for the medical professional liability line of insurance in an individual state is relatively fixed in the short run. This over supply of insurance, referred to as excess capacity, caused the carriers entrenched in the market place to keep their prices as close to their breakeven point as possible. This is the classic approach used by most American businesses when dealing with too much supply or weak demand in a free market economy. Managers then rely on competition to thin out weak or under-priced competitors.

Although this solution took longer than expected because there were so many carriers writing business here, that is precisely what happened in Florida. The prolonged soft market decimated the domestic market. At its start there were seven trust funds, a popular insurance mechanism no longer permissible under Florida law, domiciled in the state. When the soft market ended in 2000, six of them had gone out of business and one had merged with a Michigan based insurer. Four of the insurance carriers whose prices were among the most predatory in Florida are now in liquidation or being placed in liquidation (Frontier, PHICO, Unisource and Legion.) Frontier, PHICO and Legion were all based outside of Florida and Unisource was a Florida domiciled carrier. Most others have withdrawn from the state. At present there are only six carriers actively doing business in the marketplace. Three of us are at our capacity for the year and are not writing new business.

Bad Investments Not An Issue

The insurance industry has been accused of making bad investments, and it is alleged that the decline in the public stock market brought on the current state of affairs. Insurance companies are highly regulated by state insurance commissioners and we are limited in the types of investments we can make. Florida law limits investments in stocks to no more than 15% of assets. At present, our company has $8,600 invested in the stock market out of a total of over $330,000,000 of invested assets. The average property and casualty insurer in the United States has 15% of its assets invested in the stock market. Most of the industry's investments are in investment grade bonds because of their secure nature. Our need for cash to pay claims is so varied and unpredictable that the bond market is the most logical place for us to invest.

The state requires us to discount our premiums for investment income we will make before we pay the money out in claims. The fact that investment yields are extremely low at the present time does negatively impact rates for the coming year. In that sense, investment returns are adding to premiums for next year, but this was not a factor in rates set for 2000 or 2001 and is not the cause of the current state of affairs.

Past Losses Cannot Be Recouped

We cannot make up for past losses, as some people have alleged. Simply put, rates are calculated on the basis of the number and cost of claims to be reported in the coming year. To that one adds the expense of their operation and a 5% load for profit, which is all that is allowed by Florida law. We cannot add in money lost in a prior year. Our rate filings are closely scrutinized by the Florida Department of Insurance.

Causes for Underwriting Cycle

At the present time, the medical professional liability line of business has a nationwide premium volume of approximately $6 billion annually. In 1990, the figure was about $4.5 billion. It is, by national economic standards, a relatively small market. Over half of the market is served by niche companies created to fill the void left by the exodus of commercial carriers in 1975. When investment yields are high, capital flows into the insurance industry at a rapid pace. Those commercial carriers that left the market in 1975 were flush with excess capital they needed to put to work to maintain their targeted return on equity. They were again attracted to the medical professional liability line by the very high premium to risk ratios. To gain market share they priced their product as low as possible to undercut the carriers committed to the line. Their goal is to increase cash flow so they have more money to invest and are able to produce more income. This practice is commonly known as "Cash Flow Underwriting."

These commercial carriers are the largest insurance companies in the world and they brought billions of dollars of capacity to a marketplace that was only $4.5 billion to begin with. This excess of capacity rushing into a fixed marketplace creates a soft market almost overnight. As indicated above, all the carriers committed to the line could do was keep prices as low as loss costs would permit and cut expenses where they could. The committed carriers lost market share and waited for loss costs to drive the opportunistic carriers out of the market and bring on hard market conditions.

The average annual growth rate demonstrated in the premium comparison shown in Table 4 was not accomplished by a smooth, linear progression. Market conditions impact premium levels in the short run. Premium amounts may fluctuate up or down in the near term depending on the level and intensity of competition. In the end, loss costs determine premium levels and those patterns take time to establish themselves. As the new entrants into the marketplace experience the losses that are an inevitable reality of this business, they are forced to raise their prices to realistic amounts. Many choose to leave the market to reduce their loss.

The hard market is a necessary part of the underwriting cycle. Without it prices would never be corrected to the levels necessary to cover losses. The problem is we must set our prices and wait three to five years to know if they were correct or not. In the meantime changes in tort law, societal trends and other social and economic factors occur. Because of the volatile nature of medical professional liability claims, at any one moment in time, premiums are either too high or too low. It is only when all of the losses

from a given year are known that we can go back and see how accurate our original estimates of loss costs were.

The only way to prevent the cycle is to protect the committed carriers from the predatory pricing practices of the opportunistic players. If our company had been able to raise its prices 5% per year from 1990 to present we would have a premium that would be sufficient for 2003's claims. Instead, due to soft market conditions, our prices were stable throughout the 1990's and there were large price increases in 2000, 2001 and 2002. If we had ignored the market and raised our prices 5% per year in the 90's, we would have lost significantly more policyholders than the 33% we did lose through our stable price strategy.

Rights of a Few to Recover Unlimited Non-Economic Damage Versus Rights of 16 Million Floridians to Access Medical Care

According to the National Practitioners Data Bank, 1,303 people in Florida recovered on malpractice claims in 2001. Of those 1,303 people, only 301 recovered in excess of $250,000. That is the threshold issue in this debate - the right of 1,303 people to have the opportunity to recover unlimited non-economic damages versus the right of 16 million Floridians to access medical care. The fact of the matter is of all of the people who recovered damages in a malpractice case in Florida in 2001, only 301 recovered more than $250,000. Those 301 people in 2001 represent the total universe of those who could be affected by a $250,000 cap on non-economic damages. Whether it should be the rights of 1,303 (or 301) versus those of 16 million people, the answer seems obvious. Our society cannot afford to be placed in the position of losing access to medical care, which will occur if prompt, effective action is not taken. Many will suffer and some will die, needlessly, if this problem is not resolved soon.

Our Recommended Solutions

- Recommend that the legislature address the caps on non-economic damages in the voluntary binding arbitration plan created by the Academic Task Force in 1987.
- Recommend that the legislature limit the recovery in voluntary binding arbitration to only those damages that could be recovered in court.
- Recommend the legislature abolish joint and several liability.
- Recommend the legislature adopt changes in bad faith law so that only the person who purchases an insurance policy can sue an insurer for bad faith.
- Recommend the legislature adopt legislation to allow physicians and patients to enter into pretreatment agreements to arbitrate any dispute between them, including malpractice claims, and recognize the right of the parties to agree to contractually limit the recovery of non-economic damages.
- Recommend the legislature adopt a law that requires out of state medical experts to obtain certification or licensure from the Florida Board of Medicine.
- Recommend the legislature allow the representatives of physicians who receive a Notice of Intent to Initiate Litigation to have the same access to prior and subsequent treating physicians do the patient's representatives.

- Recommend the legislature change the standard of proof of medical negligence to clear and convincing evidence.
- Recommend the legislature increase the time frame that defendants have to respond to proposals for settlements.
- Recommend the legislature make the response time that defendants have to respond to a demand letter for settlement to a minimum of 30 days.

We stand ready to further address and explore these issues with the Task Force.

Slide Presentation To Governor's Task Force

Initial Presentation

By Robert E. White, Jr.

October 21, 2002

ROBERT E. WHITE, JR.

EXECUTIVE VICE PRESIDENT
CHIEF OPERATING OFFICER

®

NOT A NEW CRISIS

- SAME CRISIS SINCE 1975
- SYMPTOMS ARE AVAILABILITY & AFFORDABILITY
- TRUE CONDITION UNDIAGNOSED & UNTREATED

THIS TIME IS DIFFERENT

- DOCTORS CANNOT ABSORB NOR PASS ON PRICE INCREASES
- DOCTORS WILL GO BARE, RETIRE, OR LEAVE STATE
- ACCESS TO CARE WILL BE AFFECTED

START WITH ACADEMIC TASK FORCE 1987 REPORT

- INSURANCE INDUSTRY SLIGHTLY LESS PROFITABLE THAN AVERAGE AMERICAN BUSINESS
- UNDERWRITING CYCLE IS DRIVEN BY LOSS COSTS
- AVERAGE SEVERITY OF PAID CLAIMS UP 14.8% FROM 1975 TO 1987

PROBLEM

FLORIDA'S LIBERAL COURT SYSTEM

BAD DOCTORS

ARE NOT THE PROBLEM

LIBERAL COURT SYSTEM

INCREASES LOSS COST

PAYOUT

YEAR	NUMBER OF PAYMENTS	INDEMNITY PAID	AVERAGE
1975	390	$10,271,910[1]	$26,338
2001	1,303	$326,052,228[2]	$250,232
% INCREASE	234%	3,074%	850%

1 Florida Department of Insurance

2 National Practitioner's Data Bank

FLORIDA INDEMNITY PAYMENTS

YEAR	NUMBER OF PAYMENTS	INDEMNITY PAID
1999	1,053	$244,942,152
2000	1,228	$319,706,647
2001	1,303	$326,052,228

PROBLEM

PICKING JURIES FROM POOL OF

LICENSED DRIVERS DECREASES

CHANCE OF DEFENSE VERDICT AND

INCREASES SIZE OF AWARDS

PROBLEM

FLORIDA DOCTORS

AND THEIR INSURERS DON'T TRUST

FLORIDA'S COURT SYTEM

PROBLEM

- 30% CASES SETTLED NATIONALLY
- OVER 50% IN FLORIDA

PROBLEM

- NATIONALLY
  - 1 payment per year for every 44 doctors

VERSUS

- FLORIDA
  - 1 payment per year for every 18 doctors

MOST COMMON LIMIT CARRIED BY DOCTORS

FLORIDA	$250,000
USA	$1,000,000

FLORIDA LOSS COSTS 1987-2001

8% ANNUAL INCREASE

PROBLEM

FLORIDA'S BAD FAITH LAWS EXACERBATE PROBLEM

PREMIUM COMPARISON JULY 1, 1983 TO JULY 1, 2002

Specialty	Dade County 7/1/1983[1]	7/1/2002[2]	Average Annual Increase
Family Practice-No Surgery	$4,310	$52,300	14.0%
Internal Medicine-Minor Surg	$7,825	$52,380	10.5%
Emergency Room	$9,777	$96,800	12.8%
General Surgery	$21,971	$174,300	11.5%
Orthopedic Surgery	$27,073	$183,949	10.6%
Obstetrics	$30,433	$201,376	10.4%
Neurosurgery	$37,569	$278,829	11.1%

Specialty	Rest of State 7/1/1983[1]	7/1/2002[2]	Average Annual Increase
Family Practice-No Surgery	$3,123	$26,810	12.0%
Internal Medicine-Minor Surg	$5,606	$26,810	8.6%
Emergency Room	$6,992	$49,649	10.9%
General Surgery	$15,705	$89,368	9.6%
Orthopedic Surgery	$19,355	$94,333	8.7%
Obstetrics	$21,679	$103,270	8.6%
Neurosurgery	$27,285	$142,989	9.1%

[1] Weighted average of FPIC, PPTF, St. Paul rates taken from the Academic Task Force for Review of the
[2] FPIC Rate
*$1million per claim/$3million annual aggregate limit

CAPPING NON-ECONOMIC DAMAGES

- PREDICTABLE LOSSES
- RATE STABILITY
- CONSTITUTIONALITY
- CONDITIONAL CAPS
- VOLUNTARY BINDING ARBITRATION

DEBUNKING MYTHS

BAD MANAGEMENT – RED HERRING

INDUSTRY USED CLASSIC FREE MARKET ECONOMIC STATEGIES TO DEAL WITH EXCESS CAPACITY

DEBUNKING MYTHS

STOCK MARKET NOT AN ISSUE

FLORIDA LAW LIMITS INVESTMENTS IN STOCKS TO NOT MORE THAN 15% OF ADMITTED ASSETS

DEBUNKING MYTHS

PAST LOSSES CANNOT BE RECOUPED

FLORIDA LAW DOES NOT PERMIT THIS

DEBUNKING MYTHS

UNDERWRITING CYCLE DRIVEN BY LOSS COSTS

THE REAL ISSUE

RIGHTS OF 1,303

VERSUS

RIGHTS OF 16,000,000

RECOMMENDED SOLUTIONS

- CONDITIONAL CAPS WITH VOLUNTARY BINDING ARBITRATION
- RECOVERY IN ARBITRATION FOR THOSE DAMAGES RECOVERABLE IN COURT
- ABOLISH JOINT AND SEVERAL LIABILITY

RECOMMENDED SOLUTIONS

- CHANGES IN BAD FAITH LAWS
- ALLOW CONTRACTS FOR MANDATORY BINDING ARBITRATION OF ALL DISPUTES BETWEEN DOCTOR AND PATIENT
- REQUIRE OUT-OF-STATE EXPERTS TO OBTAIN CERTIFICATES FROM FLORIDA BOARD OF MEDICINE

RECOMMENDED SOLUTIONS

- EQUAL ACCESS TO PRIOR AND SUBSEQUENT TREATING PHYSICIANS
- REQUIRE A STRICTER STANDARD OF PROOF LIKE "CLEAR AND CONVINCING EVIDENCE" IN MEDICAL NEGLIGENCE CASES

RECOMMENDED SOLUTIONS

- INCREASE RESPONSE TIME FOR DEFENDANTS FOR PROPOSALS FOR SETTLEMENTS AND POLICY LIMIT DEMAND LETTERS

FPIC®

Insurance Solutions for Healthcare Providers

November 1, 2002

Lindsey Miller
Governors Select Task Force on
Healthcare Professional Liability Insurance
4052 Bald Cypress Way, Bin A02
Tallahassee, FL 32399

Dear Ms. Miller:

At the October 21, 2002 Task Force meeting, Neal Roth, who spoke on behalf of the Academy of Florida Trial Lawyers, presented certain data to you regarding the two largest insurers of Florida physicians, "FPIC" and ProAssurance. The data Mr. Roth presented is data from the two holding companies that own First Professionals Insurance Company (FPIC Insurance Group) and ProNational (ProAssurance). We are writing on behalf of First Professionals Insurance Company to correct some of the impressions Mr. Roth's presentation may have created regarding our company.

As mentioned above, we are a wholly owned subsidiary of FPIC Insurance Group (FIG). FIG owns several other companies besides First Professionals Insurance Company. We operate in three separate divisions. First Professionals is in the insurance division along with Anesthesiologists Professional Assurance Company based in Coral Gables, Florida, and Intermed Insurance Company and Interlex Insurance Company, both of which are based in Springfield, Missouri. We also have a reciprocal management division which manages insurance operations owned by others and a third party claims administration division which administers employee benefits and worker's compensation claims for self insureds.

Mr. Roth showed the Task Force data on two slides titled "Florida's Two Largest Medical Malpractice Insurers Are Healthy and Profitable" during his presentation. The first slide he presented represented profitability between 1991 and 2001. The data he presented is that of FIG, our parent company, and not First Professionals Insurance Company. The figures Mr. Roth utilized relate to the combined income from all operations of FIG.

We are attaching First Professionals Insurance Company's 2001 Annual Statement as filed with the Florida Department of Insurance and direct your attention to page 4, line 7, Net underwriting gain or (loss). As you can see, First Professionals Insurance Company sustained an underwriting loss of $28,563,405 in 2000 and an underwriting loss of $25,021,389 in 2001. Even after including investment and other income, our company sustained an after tax loss of $6,792,010 in 2000 and $6,623,165 in 2001. By using the data from FIG and portraying it as our company's data, Mr. Roth would have you believe that we made $600,000 in 2000 and $2,900,000 in 2001.

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Internet Address: http://www.fpic.com

In addition, Mr. Roth presented a second slide titled "Florida's Two Largest Medical Malpractice Insurers Are Healthy and Profitable." The second slide purports to show the growth in First Professionals' capital of 259% between 1991 and 2001. Again, this slide is the growth in capital of all of FIG's combined operations drawn from statements utilizing Generally Accepted Accounting Practices (GAAP) methodology. First Professionals Insurance Company surplus grew 165% between 1991 and 2001. On December 31, 1998 our surplus stood at $104,300,000. On December 31, 2001 it stood at $91,700,000. We have lost 12.1% of our capital base since December 31, 1998. The figures regarding our surplus can be found in our Annual Statement on page 22, line 27, Total Adjusted Capital. The Florida Department of Insurance requires insurers to report utilizing Statutory Accounting methods.

Mr. Roth also made mention of the fact that "FPIC" recorded an impairment charge of $29.6 million, net of $18.8 million in income taxes in the first quarter of this year related to goodwill carried on our books for other entities we have acquired. He implied that this, together with losses taken in our accident and health book, are the real reasons we are raising premiums in the medical professional liability line. He suggested that we were using less than honest accounting techniques to hide the truth and that these losses were the reason we have raised the rates we charge our policyholders.

Here, again, Mr. Roth is using the financial statements of our parent company, FIG, to confuse the issue. The impairment charge was a one time, non-cash adjustment to FIG's financial statements. The adjustment is required of every corporate entity in America during 2002 under ruling 142 by the Financial Accounting Standards Board. The adjustment made related entirely to our two noninsurance divisions - there was no impact whatsoever on First Professionals Insurance Company by the adjustment our parent company made.

As far as our health insurance losses are concerned, they are detailed in our Annual Statement on page 24 FL, line 13 and page 24GT, line 13. As of January 1, 2002 we are out of that line of insurance because of its unprofitable nature. You can rest assured that the Florida Department of Insurance will not allow us to include losses in accident and health in the formula for determining our medical professional liability premiums. The rate making formula utilized in Florida does not allow any insurer to recoup past losses, regardless of the line of business they are sustained in.

During his presentation, Mr. Roth cited the salaries earned by certain executives employed by FIG and reported to the Securities and Exchange Commission (SEC) in our annual filings. He indicated that the Academy of Florida Trial Lawyers had done a comparison with other insurance executives and found that our employee's salaries "...were in the 90th percentile." In attempting to ascertain the source of his statement we researched the filings made by our parent company with the SEC going back to 1998. We found that of all of the individuals whose compensation was reported, only one, David L. Rader, was assigned to First Professionals Insurance Company. Based on a study by Frederic W. Cook & Co., a nationally known firm specializing in executive compensation, Mr. Rader's 2001 compensation was substantially below

the median 2001 compensation for our peer group. All of the others who are listed by the company in those reports are assigned to manage our holding company's operations. The compensation of individuals managing FIG's operation are more properly compared to that of individuals managing other holding companies rather than to individuals who manage insurance companies. Having said that, we believe our overall compensation levels are reasonable or even conservative compared to our peer group. For example, the Frederic W. Cook & Co. study indicates that (i) the 2001 compensation for the CEO of our parent company is below the median for our peer group and (ii) the 2001 compensation levels for the five top executives in our organization are generally between the market 25th percentile and the median. Relevant pages from the Frederic W. Cook & Co. study are included with this letter.

Lastly, we are pleased that Mr. Roth's opinions about our company's profitability and financial strength are so positive. Unfortunately, we must report that on October 23, 2002, A. M. Best Company, the world renown insurance company financial strength rating agency, lowered its rating of all of FIG's insurance companies, including First Professionals Insurance Company, from A- (Excellent) to B++ (Very Good). Best's actions reflect their general discomfort with medical professional liability line of insurance. They have downgraded several companies writing this line this year and will, in all probability, downgrade several more in the months to come. In spite of Best's rating action, First Professionals Insurance Company remains financially strong and stable.

First Professionals Insurance Company and its sister company, Anesthesiologists Professional Assurance Company, are the last two remaining Florida domiciled insurance carriers. We face strong challenges from increased loss costs and Florida's onerous bad faith laws created by our state's liberal court system. The only way our company can provide relief to its policyholders from the rate hikes currently plaguing Florida's physicians is through effective tort reform. In the past, our legislature has only been willing to enact such legislation when following recommendations from blue ribbon panels such as yours. We implore you to enact the recommendations outlined in our written presentation to the Task Force so that premiums can be stabilized.

Sincerely,

Robert E. White, Jr.
President

enclosures

Slide Presentation To Governor's Task Force

Insurance Code Reform

By Robert E. White, Jr.

November 22, 2002

ROBERT E. WHITE, JR.

PRESIDENT

INSURANCE CODE REFORM

- NECESSARY TO PREVENT PREDATORY PRICING PRACTICES OF PAST
- CASH FLOW UNDERWRITING DESIGNED TO TAKE ADVANTAGE OF HIGHER THAN USUAL INVESTMENT RETURNS

FLORIDA MARKET

- 1990-TOP FIVE CARRIERS PLUS SEVERAL PERIPHERAL PLAYERS
- 1995-OVER 40 CARRIERS SCRAMBLING FOR MARKET SHARE
- SOME CARRIERS CHARGING 60% BELOW AVERAGE RATE OF TOP 5 CARRIERS

DEBUNKING MYTHS

BAD MANAGEMENT – RED HERRING

INDUSTRY USED CLASSIC FREE MARKET ECONOMIC STRATEGIES TO DEAL WITH EXCESS CAPACITY

FLORIDA MARKET

- 2002-ONLY 5 CARRIERS ACTIVE IN THE STATE
- ONLY 2 OF TOP FIVE CARRIERS IN 1990 REMAIN
  - OTHER 3 BANKRUPT
- FPIC DOWNGRADED BY A.M. BEST
- ENTIRE INDUSTRY WEAKENED BY PRICE COMPETITION OF 1990'S

RECOMMENDED SOLUTION

- RECOMMEND CHANGES TO FS 627.062 RATE STANDARDS, TO REQUIRE THAT RATES BE MADE USING FLORIDA LOSS DATA ONLY:

FS 627.062

7. A medical malpractice rate shall be deemed inadequate and unfairly discriminatory if the rate for any specific classification is more than ten percent lower than the average rate charged, after applying premium discounts, deviations or credits, by the three largest writers of medical malpractice in this state, unless that rate can be actuarially supported utilizing only loss costs developed from this state's loss experience for any classification or an expense savings demonstrated to be actuarially sound by the insurer.

Slide Presentation To Governor's Task Force

Non-Economic Damage Cap

By Robert E. White, Jr.

December 4, 2002

ROBERT E. WHITE, JR.

PRESIDENT

®

LIBERAL COURT SYSTEM

INCREASES LOSS COST

PROBLEM

- 30% CASES SETTLED NATIONALLY
- OVER 50% IN FLORIDA

PROBLEM

- NATIONALLY
  - 1 payment per year for every 44 doctors

VERSUS

- FLORIDA
  - 1 payment per year for every 18 doctors

PAYOUT

YEAR	NUMBER OF PAYMENTS	INDEMNITY PAID	AVERAGE
1975	390[1]	$10,271,910[1]	$26,338
2001	1,303[2]	$326,052,228[2]	$250,232
% INCREASE	234%	3,074%	850%

1 Florida Department of Insurance

2 National Practitioner's Data Bank

FLORIDA INDEMNITY PAYMENTS

YEAR	NUMBER OF PAYMENTS	INDEMNITY PAID
1999	1,053	$244,942,152
2000	1,228	$319,706,647
2001	1,303	$326,052,228

Source: National Practitioner's Data Bank

FLORIDA LOSS COSTS 1987-2001

8% ANNUAL INCREASE

DEBUNKING MYTHS

UNDERWRITING CYCLE DRIVEN BY LOSS COSTS

PREMIUM COMPARISON JULY 1, 1983 TO JULY 1, 2002

Specialty	Dade County 7/1/1983[1]	7/1/2002[2]	Average Annual Increase
Family Practice-No Surgery	$4,310	$52,300	14.0%
Internal Medicine-Minor Surg	$7,825	$52,380	10.5%
Emergency Room	$9,777	$96,800	12.8%
General Surgery	$21,971	$174,300	11.5%
Orthopedic Surgery	$27,073	$183,949	10.6%
Obstetrics	$30,433	$201,376	10.4%
Neurosurgery	$37,569	$278,829	11.1%

Specialty	Rest of State 7/1/1983[1]	7/1/2002[2]	Average Annual Increase
Family Practice-No Surgery	$3,123	$26,810	12.0%
Internal Medicine-Minor Surg	$5,606	$26,810	8.6%
Emergency Room	$6,992	$49,649	10.9%
General Surgery	$15,705	$89,368	9.6%
Orthopedic Surgery	$19,355	$94,333	8.7%
Obstetrics	$21,679	$103,270	8.6%
Neurosurgery	$27,285	$142,989	9.1%

[1] Weighted average of FPIC, PPTF, St. Paul rates taken from the Academic Task Force for Review of the
[2] FPIC Rate
*$1 million per claim/$3 million annual aggregate limit

CAPPING NON-ECONOMIC DAMAGES

- JURY AWARDS ARE THE YARDSTICK AGAINST WHICH ALL SETTLEMENTS ARE MEASURED
- LOWERS POTENTIAL JURY VERDICTS
- PREDICTABLE LOSSES
- RATE STABILITY
- DOES NOT IMPACT RECOVERY FOR PAST OR FUTURE ECONOMIC LOSS

THE REAL ISSUE

- 1,303[1] FLORIDIANS RECOVERED DAMAGES IN A MEDICAL PROFESSIONAL LIABILITY CLAIM AGAINST A PHYSICIAN IN 2001
- OF THOSE 1,303, ONLY 301[1] FLORIDIANS COLLECTED AN AMOUNT GREATER THAN $250,000

[1]National Practitioners Data Bank

THE REAL ISSUE

RIGHTS OF 301 TO COLLECT UNLIMITED NON-ECONOMIC DAMAGES

VERSUS

RIGHTS OF 16,000,000 FLORIDIANS TO ACCESS HEALTH CARE

CAPPING NON-ECONOMIC DAMAGES

ABSOLUTE $250,000 CAP WILL HAVE THE GREATEST IMPACT

INDEX - FLORIDA

General Rules

Binding Authority and Policy Effective Date

Coverage will not be bound until a properly completed application has been received and approved by the Company. Only the Company may bind coverage or issue a Memorandum of Insurance.

The earliest effective date coverage can be bound will be the date the application is received by the Company. Under no circumstances will coverage by issued prior to the date the applicant was licensed in the state to practice medicine.

The Company will make all determinations of acceptability of coverage.

Policy Period

The policy is issued for an annual term. Exceptions to this rule may appear elsewhere in this manual.

Rates

Rates for each available limit of liability and for each territory are provided in Section 2 of this manual. There is a separate rate sheet for each retroactive year. Specialties are listed for each rate class in accordance with the classifications listed in Section 3.

If two or more classifications apply to the same physician, the classification with the higher rate will apply. Additionally, if the physician's practice is in two or more territories, the territory with the highest rate will apply. The Company will review such classification and territory designations for exceptions if they involve a minimal portion of the physician's practice. Each such case must be individually submitted for consideration.

The specialty and classification designations included in Section 3 may not be all inclusive. In some cases, certain procedures deemed to be of higher risk may result in the different classification.

General Rules - continued

Premium Calculations

The premium applicable to each classification or miscellaneous charge is determined by the retroactive date and the policy effective date. The premium is determined by the number of years the retroactive date precedes the effective year. Use the rate sheet applicable to the retroactive year to find the rates which apply to the policy.

If the retroactive month/day does not coincide with the policy effective date, the premium retroactive year is determined by the number of days between the two. If the retroactive month/day is 183 days (or less) before the effective month/day, use the effective month/day to determine the retroactive year premium to be used. If the retroactive month/day is 184 days (or more) before the effective month/day, use the prior year to determine the retroactive year premium.

Certain coverages may have an individual retroactive date. These are Designated Employee Coverage and Professional Office Liability Protection. Rates for these coverages are determined by their individual retroactive dates.

Premiums apply for each individual on the policy, and for each miscellaneous charge which might apply to that individual.

Endorsement changes will be rated in accordance with the rates in effect at the inception date of the policy or renewal being amended. "Tails" will be issued at the rates in effect at the time of cancellation of the policy.

Limit Changes

Changes in the limit of liability require a signed request by the physician. No change can be made until the request has been received by the Company, and will be effective on the date received unless a later date is specified.

All limit changes are retroactive as respects future claims from incidents which the insured was not aware might result in a claim, as of the effective date of the change. An acknowledgment of this will be sent to the insured to be signed and returned to use for every limit increase.

Increased limits are subject to underwriting approval. Limit decreases to $250,000 / $750,000 are available upon request. To qualify for a reduction to $100,000 / $300,000, the physician must confirm that no hospital privileges are in effect.

General Rules - continued

Cancellations

Unless a policy is canceled as of inception or anniversary, the return premium will be computed on the basis of 90% of the pro rata return premium. Exceptions: cancellations at the request of the Company, with a 60 day notice; cancellations due to the death of the insured; cancellation due to disability which qualifies for free tail; cancellation when fully retiring.

Prior notification will be provided for any cancellation by the Company. Sixty days prior notice for cancellation by the Company for cause; ten days prior notice or non-payment of premiums due; ten days prior notice for cancellation due to loss of license to practice medicine.

Any request for cancellation by the insured must be signed by the insured, and contain the effective date of cancellation as well as the policy number. Once a policy is issued, failure to pay premiums due will NOT void a policy; a specific request for cancellation must be made. Otherwise, the Company is required to provide a ten day advance notice of cancellation which will result in an earned premium charge for the coverage period.

ELIMINATED

Extended Reporting Period Coverage (Tail)

Refer to the policy for rules governing this coverage.

A policy canceled at any date after the original inception date is eligible for this coverage. An option to purchase this coverage will be provided by the Company, as part of the cancellation processing. Thirty days will be provided in the option period; after this period has expired, the coverage will no longer be available.

When purchased, "tail" coverage will be subject to an experience rating plan based on the claim experience of the prior active coverage as of the effective date of cancellation. The total indemnity payments and reserves at the time of cancellation will be divided by the total liability premium paid while insured, to determine the experience factor to be applied to the lump-sum tail charge.

Loss Ratio	Experience Factor
75% or less	0.75
75% to 100%	0.85
100% to 125%	1.00
125% to 150%	1.15
150% to 175%	1.30
175% to 200%	1.40
200% or more	1.50

"Tail" processing is handled by the Company, based on the current filed rates in effect at the time of cancellation. Please contact the Company for a quotation if the coverage is desired.

Locum Tenens Coverage

If temporary coverage is required for a physician providing substitute coverage for an insured, a locum tenens policy may be issued or limited coverage may be added to the insured's policy by endorsement.

A potential locum tenen must submit a regular application for underwriting review and be licensed to practice medicine in the same state as the insured physician. The locum tenen must be employed by and providing temporary coverage for one of our insureds.

Upon approval, an option will be offered to issue on the following:

1. Endorse the insured's policy to cover ONLY professional services rendered on behalf of our insured physician for the time period specified. There will be a shared limit of liability, and no premium charge will apply. No individual "tail" coverage is available.

   This endorsement (127) is limited ONLY to situations where a locum tenens is replacing an insured who will not be otherwise practicing during the coverage period. A signed option form (128) must be on file for this option.

2. An individual policy will be issued for the employee, then canceled on a pro-rata basis. Lump-sum "tail" coverage will be issued on a pro-rata basis for the coverage term. The policy and "tail" coverages must be paid in full. Under this option, the "tail" coverage is not optional.

Coverage under this rule will not be in effect for more than 180 consecutive days.

Premium Adjustment for Class or Territory Change

When an individual changes to a lower rated classification or territory, there is a continuing exposure to claims from the prior class or territory. In order to provide for this continuing exposure, a form of "tail" charge shall be applied.

The charge will be based on the difference between the "tail" charge for the old classification and the new classification. It will be computed on a three-year payment basis, utilizing the "tail" rates and procedures in effect on the effective date of the policy or renewal being changed.

The original retroactive date will be maintained for the new classification and / or territory. If the policy subsequently canceled, any "tail" premium applicable will be based only on the new classification and / or territory plus any remaining premium due for the change adjustment.

If an insured becomes eligible under the terms of the policy for free "tail" coverage, any remaining charge for the change adjustment will also be considered within the terms of the free "tail" coverage.

Physicians who become disabled may be submitted for special consideration under this rule. The term "disabled" will include pregnancy. If eligible for disability, Class 1 through 2 physicians may be reduced to Class 0. Class 3 and above may be reduced to Class 1.

An insured who is already eligible for free "tail" coverage upon full retirement, may reduce to a lower classification without a premium adjustment.

An insured changing to a higher rated class or territory should be submitted for rating.

Coverage Form

All coverages are written on a claims-made basis. All new policies issued with a retroactive date equal to the coverage effective date, unless the applicant is approved for Prior Acts Coverage. This coverage is provided by the use of a retroactive date prior to the new coverage effective date and is subject to specific approval by the Company.

[redacted] provides individual coverage with a provision for the inclusion of a Professional Association, Partnership, or Corporation to which the individual may belong and includes coverage only for the actions of the individual named as insureds. No matter how many persons or organizations may be named, only one limit of liability will apply.

[redacted] provides coverage for groups. The policy is written in the name of the organization, with individuals scheduled on a master policy. There is no separate limit for the organization if any physician scheduled in the policy is named. It is available for groups of 2 or more physicians.

Designated Employees Coverage

Designated Employee Coverage is available for certified Physician's Assistants, Nurse Anesthetists, Nurse Practitioners, and Nurse Midwives who are employed by our insured. The Designated Employee will be specifically named on the policy, but no additional limit of liability will apply.

This coverage is required for employed certified Physician's Assistants, Nurse Anesthetists, Nurse Practitioners, and Nurse Midwives; or they must provide proof of individual coverage for a minimum limit of $250,000 / $750,000. If they are not insured as Designated Employees, or have approved coverage elsewhere, the insured is not covered for any liability for the actions of such an employee.

Specific applications are required for each Designated Employee and should be requested from the Company before the employee begins working for the insured. As is the case with physician applicants, each application is subject to prior approval by the Company before the coverage may be added. Coverage cannot be effective prior to receipt of notification.

The rates applicable to Designated Employees, along with the definitions of the rate categories are included in the rate section of this manual.

A charge will apply for the employer's vicarious liability for each employee of the insured who does not have coverage on a FPIC policy. The charges for vicarious liability are included in the rate section of this manual.

No premium charge is made for Nurse Anesthetists, or for the vicarious liability for employed Nurse Anesthetists. All of the above rules still apply, and any Designated Employees will still be shown on the policy.

Broad Form Investigation Defense Coverage

Coverage	Investigation conducted by:	Investigation related to
[redacted]		

Coverage	Limit per Physician	Deductible	Premium per Physician
[redacted]			

The incident causing the investigation must have occurred after the policy retroactive date, and the investigation must have commenced after the date that the optional coverage was added to the policy.

The maximum group coverage for the Broad Form Investigation Defense Coverage is based on the size of the group.

Group Size	Group Annual Aggregate
2 - 4	$50,000
5 - 9	$100,000
10 - 25	$150,000
26 +	$250,000

New Physician Discount

A new physician entering the first year of private practice following completion of residency or a fellowship program in their specialty may be eligible for a discount. A 65% discount applies to first year claims made rates. A 30% discount applies to second year claims made rates. A 15% discount applies to third year claims made rates. Thereafter, standard rates apply.

This discount is subject to Company approval, and may not be used if prior acts coverage applies.

This discount replaces any other applicable discount.

Part-Time Practice Rate Discount

A physician may qualify for a part-time rate only if:

1. practice does not exceed 1,000 hours per year. The approximate practice time must be determined and will include the time the physician spends in patient care (including hospital rounds, completion of medical records, and consultations).

2. the part-time practice is permanent, or of a long-term duration of at least one year, except for pregnancy. Maternity leave will be for at least three months and not to exceed twelve months.

Eligibility for a part-time practice discount is subject to Company approval in all cases. Annual verification of eligibility is required, along with any special documentation which the Company may deem necessary. Policies issued under this rule will be written with the following discount applied to the annual premium otherwise applicable:

<u>New policies with no prior acts coverage</u> 50% discount

<u>New policies with prior acts coverage</u> -

1. If the part-time start date is the same as the retroactive date, 50% discount.
2. If the part-time start date is after the retroactive date, the applicable discount will follow the schedule listed below for current insureds.

<u>Current Insureds</u>:

When a current insured becomes eligible for a part-time rate mid-term, the existing policy will be endorsed to reflect the appropriate discount.

Rates will be phased in over a period of time to reflect a premium adjustment for continued exposure of the prior acts practice activity. If the insured has been with FPIC long enough to qualify for free tail if retired, the 50% discount will apply.

The discount applicable will be determined by the number of years at the part-time activity:

First year	10%	Third Year	30%
Second year	20%	Fourth Year	50%

Part-time and loss free discounts can be combined for those in the first three years of part-time activity.

Sabbatical / Leave of Absence

A physician is provided premium relief when taking a leave of absence (including continuing education) or a sabbatical when it exceeds 45 days. It cannot be used for vacation time.

Eligibility under this rule is subject to Company approval in all cases. To determine eligibility, the Company requires a signed statement from the insured stating the reason for the leave, the starting date and the anticipated ending date.

Discounts for eligible physicians:

Class 0 premium may be reduced by 50%.

Class 1, 1A, 1B, 1C, 1D, 2, 2A, 2B, 2C may be reduced to class 0.

Class 3 and above may be reduced to class 1.

The classification will be returned to the original status upon notification of return to practice. No premium adjustment will be charged for this period of time.

Corporation Coverage

Optional coverage with a separate limits of liability for a professional association, corporation or partnership is available for groups of 2 or more physicians, and can be purchased by groups insured under the large group (clinic) policy or insured individually, but as part of a professional association, corporation or partnership.

If all physicians members (shareholders or partners) are not insured with FPIC, they may be added to the corporate coverage schedule, subject to underwriting approval, upon proof of acceptable individual coverage at the same limit (or higher) as the corporate limit. Otherwise, there is no corporate coverage for their actions.

Ancillary personnel are covered under the corporate coverage as long as they are acting within the scope of their employment, even if working with an individual physician not included in the physician schedule.

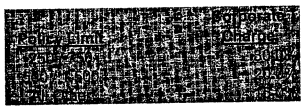
Employed physicians insured elsewhere may be added to the schedule of physicians included in the corporate coverage with appropriate proof of other insurance (as is currently required). In this case, the usual vicarious liability charge will not apply; they will be rated as if they were insured physicians.

Charges for Designated Employees and other vicarious liability charges will be added to the corporate coverage on the same basis as is currently required.

Retroactive coverage for the corporate coverage can be considered. If approved, the same affidavit used for individual coverage will be used for the corporate coverage. The affidavit must be signed by the President of the organization applying for the coverage. If all members (including employed physicians) do not have the same limit of liability individually, the limit available for the organization is the lowest limit of any individual physician scheduled.

Corporation Coverage - continued

RATES:



If the physician rate is discounted or surcharged, the final rate will be used to determine the charge.

If the retroactive date of the optional corporate coverage is later than the physician retroactive date, the physician rate for corporate coverage will be recomputed based on the corporate retroactive date for purposes of determining the corporate charge.

If the scheduled physician is not insured with FPIC, the corporate charge is based on the charge which would apply if insured by us.

Participation in Birth-Related Neurological Compensation Association (NICA)

Each eligible physician who provides proof of membership in Florida NICA shall receive a credit to their premium of up to $4,750. The credit will be applied to the premium before application of any discounts which might apply to the policy.

Proof of NICA participation shall be furnished in writing by submission of a certificate. In the event proof cannot be furnished by the physician, a phone call to NICA may be acceptable. An endorsement and modification of monthly payment schedule will be completed upon receipt of proof of participation.

If a current insured is a member of NICA as of 01/01/91, or if a physician joins NICA after January 1 of any year, and the policy in force at that time expires prior to the next January 1, the credit will be pro-rated from the date the NICA fee is paid to the next policy anniversary. At renewal, the full credit of $4,750 will be applied.

If any insured fails to remain a member of NICA as of any January 1, the credit will no longer apply as of that date. The pro-rated credit from January 1 to the next policy anniversary date will be due the Company. This amount will be added back to the policy and remaining installment payments adjusted, or will be billed to the insured if the policy has been paid in full.

If a physician receiving credit cancels mid-term, the earned and return premium will be computed on the undiscounted class premium. A pro-rated credit from addition date to cancellation date will be deducted from the earned premium.

Hospital Medical Staff Groups / Medical Groups

A Hospital Medical Staff Group is eligible for the premium discounts shown below. Coverage will be provided by issuing policy form [redacted], which provides individual limits for each physician. Physicians currently insured with FPIC will be eligible to enter a group program at their individual anniversary date. If entering at a date other than the Group effective date, new business and converting business will be issued a short term policy to expire on the anniversary date of the group. The rates in effect at the time of the effective date of the group shall apply to all individuals entering during that one-year period.

[redacted]

This discount may not be combined with the Endorsed Carrier Discount shown on Page 33-U or the Expense Savings Discount plan shown on Page 34-U.

"Refer to Company" Rating Rule

This rule applies when:

(1) The premium developed by applying the $1,000,000 / $3,000,000 mature claims made manual rates to the exposure base exceeds $100,000; or

(2) The exposure base is greater than or equal to 5 physicians

The rates, rating rules, rating programs, underwriting rules and coverage provided will be mutually agreed upon by the parties.

Supporting documentation will be maintained by the company for a period of at least 5 years after the effective date. All required reporting shall be done in accordance with applicable state statutes and regulations.

[redacted]

Claim Surcharge Program

The premium applicable to those physicians who have experienced more than two "chargeable" claims in excess of $10,000 over a period of seven (7) years may be surcharged in accordance with the following table:

2 chargeable claims	50% surcharge
3 chargeable claims	150% surcharge
4 or more chargeable claims	500% surcharge

Each and every claim shall have a determination of whether or not it is "chargeable". The surcharge once assessed shall apply for a three year period commending on the next renewal date, regardless of the date of the chargeable loss. An additional chargeable loss occurring under an already surcharged period shall start a new three year period.

Laser Refractive Surgical Procedure Surcharge

Ophthalmologists may perform Laser Refractive procedures (of any type including, but not limited to: RK, PRK, Lasik, etc.) on 400 patients annually at standard rates.

A surcharge will be applied if Laser Refractive procedures (of any type including, but not limited to: RK, PRK, Lasik, etc.) are performed on more than 400 patients per year.

- 401 to 500 patients annually - 50% surcharge
- 501 or more patients annually - submit to Company

Schedule Rating Program

The Company has determined that significant variability exists in the hazards faced by physicians engaged in the practice of medicine. Exposure conditions vary with respect to:

Exposure Condition	Credit	Debit
Qualifications / Training / Continuing Education, including: • Board Eligibility or Board Certification • Hospital Affiliations or Staff Privileges • Experience in Specialty • Accreditation	7.5%	7.5%
Practice Patterns including patient load and support staff	10%	10%
Patient Documentation and Follow-up	5%	5%
Employee selection, supervision, training, and experience	5%	5%
Compliance with applicable regulations (OSHA, CLIA, etc)	5%	5%
Cooperation with Underwriting / Claims / Defense Counsel	5%	5%

In recognition of these factors, the Company will apply a debit or credit to the otherwise applicable rate based upon the underwriter's overall evaluation of the risk.

The maximum credit will be 25%
The maximum debit will be 25%

Chiropractors

Chiropractors eligible for coverage will be written using [redacted] and attachment of [redacted]. All rates and rules except those specified herein shall apply to chiropractors.

Classification: 80410

Interns / Externs -

An intern / extern may be added to the named insureds policy for an additional premium of 10% per individual. Use FPIC-149 (3/96) for the purpose of adding interns / externs.

Corporation -

A professional corporation owned by an insured may be added to the policy but it will have a shared limit with the insured. In he event a separate limit is requested, refer to the rules regarding separate limits contained in this manual.

Manipulation under Anesthesia

This procedure has been excluded from coverage under [redacted]. In the event an insured meets the underwriting criteria, this coverage may be added back by attaching FPIC-150 (3/96) and payment of an additional premium of 10%.

Extended Licensing Investigation Coverage

The named insured may at their option add the extended licensing investigation coverage endorsement referred to in this manual at an annual cost of $250.

Designated Employee Coverage

Certified Chiropractic Assistants may be added to the policy in accordance with the rules for Designated Employees. The additional charge for adding a Certified Chiropractic Assistant will be 10% of the Chiropractor rate. All other types of employees will be added in accordance with the rules contained in this manual.

Vicarious Liability

A charge will apply for the employer's vicarious liability for each employee of the insured who does not have coverage on a FPIC policy. The charges for vicarious liability are included in the rate section of this manual.

Full-time Equivalent Rating

Rating for certain multi-physician groups may be written on a full-time equivalent basis. This is at the Company's option. Under this method, policies will be issued to cover positions rather than specific individuals. The FTE rate will be determined based on the filed and approved rate for the classification of physician or surgeon, but will be allocated based on the average number of patient contacts / visits in a 12 month period. One FTE is defined as follows:

Emergency Medicine	5,400 emergency room visits per year
Outpatient Clinic:	10,000 outpatient clinic visits per year

In the event a position is eliminated, the Named Insured shall purchase a reporting endorsement for that position.

Vicarious Liability for Supervision of Nurse Midwives (not employed by the insured)

For an additional charge of 5% of the premium for each nurse midwife supervised, FPIC will provide coverage within your existing limits of liability to cover the vicarious exposure.

Additionally, each nurse midwife must furnish evidence of insurance which specifies limits of liability greater than or equal to $250,000 per person and $750,000 annual aggregate. Self-insuring programs and other coverage deemed acceptable by the Department of Insurance will be satisfactory to meet this requirement.

Premium Experience Return Plan

Eligibility

The group is eligible to share in the total profits of the plan with FPIC provided total group premium is greater than $500,000. If the group's premium level does not reach this level before six months of the policy year have elapsed, the premium experience return plan will not activate until the next policy year. Otherwise, the plan will activate effective on the current policy inception date.

Calculations and Closure

The profits for each policy year are determined 48 months after the policy effective date, and annually thereafter until a policy year is closed. There must be at least 3 continuous years of total program experience available.

The profit are calculated for each year by subtracting the loss and allocated loss adjustment expenses from 75% of the eligible premium.

Profits amounts are calculated for the individual policy year and for the total of all policy years (using at least the three years of experience as described above). The results are compared and the final profit for the policy year is capped at the lower of the total profit amount for all years less any previously returned profit amounts or the individual policy year profit amount. 30% of the final policy year profit is available for return to the group.

After final profits are calculated, a determination of closure must be made (for policy years with pending claims) by the governing body of the group.

1. If the group elects to close the policy year, indicated returns will be distributed to the members of the group as described below.

2. If the group elects to leave the policy year open, no returns will be distributed and the policy year will be re-evaluated in 12 months.

A policy year will be deemed closed by FPIC if all claims have closed, provided at least 48 months have passed from the policy effective date.

Premium Experience Return Plan - continued

Definitions

Profits are determined on a group basis using the following formula:

Premium - Expenses - Losses

Premium is defined as the amount paid by the group to FPIC for professional liability insurance coverage. Finance charges are not considered eligible premium. The eligible premium is capped at $500,000 limits (or policy limits, whichever is lower).

Expenses are company fixed costs and are defined as 25% of Premium.

Losses are defined as paid and reserved indemnity plus paid and reserved allocated loss adjustment expense. Paid and Reserved Indemnity amounts are capped at $500,000 per claim (or policy limits, whichever is lower).

Return Mechanism

Upon closure of the policy year, indicated profits will be returned to group members based on a ratio of their individual premium to the group premium as a whole.

In order to receive profit returns, an individual must have been insured with FPIC in the policy year being evaluated and must have a current policy (or a tail endorsement resulting from the invocation of the death, disability or retirement provision) with FPIC.

Profits allocated to members no longer with the group will be reallocated to remaining members of the group.

Retrospective Rating Plan

A retrospective rating endorsement shall be attached to all policies listed on the Schedule. The retrospective premium shall be determined by using the combined experience of all policies listed in that Schedule and may include any or all of the following lines of business: Professional Liability, General Liability, Workers Compensation, Boiler and Machinery, Commercial Auto, Commercial Inland Marine, Commercial Property, Commercial Crime, Commercial Glass or Commercial Multi-Line.

If the sum total of all policies standard premium to be included in the plan exceeds $350,000, the retrospective rating plan elements shall be mutually agreed upon by the insurer and the insured. Otherwise, the rating elements will be defined in the Retrospective Rating form and on the remainder of this page.

Retro Premium =

[(Subject Premium x BPF) + (Incurred Loss x LCF)] x TM

Rating Element	Factor	Definition
Subject Premium	N/A	Premium attributable for all exposures eligible for retro rating.
BPF	TBD	Basic Premium Factor - includes charges for insurer general expenses, broker commissions and insurer profit and contingencies and a charge to limit losses to a maximum premium. Determined for each policy based on premium size and maximum and minimum factors
Incurred Loss	N/A	Paid losses plus case reserves plus a load for IBNR. Includes Allocated LAE.
LCF	1.050	Loss Conversion Factor - charge for insurer claims handling functions that are not allocated to specific claims.
TM	1.070	Tax Multiplier - charge for insurer licenses, assessments, state premium taxes, assigned risk surcharges and guaranty funds.

Podiatrist

Podiatrists eligible for coverage will be written using [redacted]. All rates and rules except those specified herein shall apply to podiatrists.

Classification: 1-80993 Minor Surgery
2-80993 Major Surgery

Corporation -

A professional corporation owned by an insured may be added to the policy but it will have a shared limit with the insured. In the event a separate limit is requested, refer to the rules regarding separate limits contained in this manual.

Vicarious Liability

A charge will apply for the employer's vicarious liability for each employee of the insured who does not have coverage on a FPIC policy. The charges for vicarious liability are included in the rate section of this manual.

Deductible Discount Program

Deductibles may apply to either damages (indemnity) or to damages and defense (indemnity and ALAE).

FPIC will advance any deductibles due to the plaintiff. We will require reimbursement from the named insured within 30 days of notification that such amounts have been paid. FPIC's limit of liability to pay damages under the policy will be reduced by any applicable deductible(s).

Deductible	Credit for Indemnity Only	Credit for Indemnity & ALAE
$5,000	2.5%	7.0%
$10,000	5.0%	12.0%
$15,000	6.5%	16.0%
$20,000	8.0%	19.0%
$25,000	10.0%	22.0%
$50,000	17.0%	32.0%
$75,000	22.0%	40.0%
$100,000	28.0%	47.0%
$150,000	35.0%	55.0%
$200,000	42.0%	62.0%
$250,000	50.0%	75.0%

The above factors apply to the $500,000 limits premiums in order to determine the appropriate premium credit. The calculated credit should then be subtracted from the total premium in order to determine the final charge.

Factors for limits not shown on table shall be determined by interpolation.

Loss Free Discount Program

Any physician who is loss free as of the original effective date of new coverage, or the renewal date of current FPIC coverage, will qualify for the following discounts:

Loss Free Years	Discount
0 - 4	none
5 - 9	10%
10 -14	20%
15 or more	25%

Loss free status will be determined on Florida experience only. The experience period will start as of the year Florida practice commenced, unless there was a period under the Florida practice when the physician went "bare". In this case, the Florida experience period will begin as of the date he/she become insured with a carrier whose "definition of claim" clause is comparable to FPIC. The number of loss free years is calculated from January 1 of the year Florida practice began, or the date of the last qualifying loss, to the physician's renewal date.

EXCEPTIONS: If the physician is currently insured with FPIC in another state, then the qualified loss free years in the other state will transfer as Florida loss free years.

If a physician is relocating to Florida from another state and can provide proof of continuous insurance coverage as well as a certified claim history, then the qualified loss free years will be accepted.

If loss free status changes between the time the renewal is issued and the actual effective date, the renewal will be reissued at the correct premium charge and the difference billed to the insured.

If a loss occurs during the year, the loss free status reverts to 0 years. However, the loss free credit will only change at renewal. In the event a reserve of $100,000 or more is subsequently settled for less than amount in definition, an endorsement will be issued to reflect all credits which were lost due to the reserve amount (if the credit exceeds the remaining policy premium, the balance will be refunded). If a reserve is subsequently paid for amount in definition, the paid date becomes the date of the last qualifying loss.

This discount may be combined with any other discount shown in the manual unless otherwise specified.

Loss Free Discount Program – continued

"Loss" as it applies to this rule is defined as:

Class 0-2

1. Any indemnity payment over $25,000 or any FPIC indemnity reserve of $100,000 or more.
2. Any indemnity payment over $50,000 or any FPIC indemnity reserve of $100,000 or more.
3. Any two claim occurrences within the last five years, (as defined in items #1 or #2 above), will result in removal of the loss free credit upon renewal regardless of #1 or #2 above.

Class 3 – 8

1. Any indemnity payment over $50,000 or any FPIC indemnity reserve of $100,000 or more.
2. Any two claim occurrences within the last five years, (as defined in items #1 or #2 above), will result in removal of the loss free credit upon renewal regardless of #1 or #2 above.

Endorsed Carrier Discount Program

[redacted]

This discount may be combined with any other discount shown in the manual unless otherwise specified.

This discount may not be combined with the Hospital Staff Groups / Medical Groups Discount shown on Page 18-U or the Expense Savings Discount plan shown on Page 34-U.

This rule applies only to policies issued using policy form [redacted].

Expense Savings Discount Program

These discounts will be applied to the sum of individual insureds premiums. All physicians must be insured with FPIC.

This discount is not applicable to tail rates.

This discount can be combined with any other discount, unless otherwise specified.

[redacted]

Size of Group	Discount
2 to 4 physicians	2.5%
5 to 9 physicians	5.0%
10 to 19 physicians	7.5%
20 or more physicians	10.0%

Risk Management Discount Program

An insured may receive up to a 5% discount (capped at $1,000) for:

- participation in company sponsored or approved risk management workshops or in-office seminars; or
- use of a company approved software systems; or
- acceptance of specialty practice guidelines; or
- employment of a full-time, qualified, professional risk manager.

This discount is not applicable to tail rates.

This discount can be combined with any other discount, unless otherwise specified.

This rule may be applied to all policy types.

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Note: Each physician may receive only one of the following discounts: Hospital Group Program, Specialty Society, or Endorsed Program. This may be combined with any applicable Loss Free discounts as defined for each program.

Alternate Risk Program

1. Credits for Part-time, NICA and deductibles are available.
2. Physician is part of program for a minimum of 2 years
3. Free tail due to retirement will be available after 5 claims free years with FPIC. Free tail due to death or disability is available at any time.
4. Tail pricing is based on manual rates in effect at time of cancellation and surcharge being applied to the canceled policy.
5. While participating in the program, physician will participate in company sponsored risk management activities.
6. Prior acts is available and offered at the Company's discretion.
7. Investigation coverage is available at a 50% surcharge if the extended coverage endorsement is selected. There is still no charge for the basic coverage.
8. Coverage for PA/PC is available if sharing in the physician's limit. No additional limit of liability will be offered.
9. Policy limits of $250,000 / $750,000 are available.

Physician Premium Surcharge Determination:

A minimum surcharge of 50% applies.

Additional surcharges of 25% to 75% are applied based on:

Claims Experience	0 - 50%
Training / Accreditation / Credentialing (including Licensing / Privileges Actions)	0 - 25%
Practice Volume	0 - 20%
Risk Management Practices	0 - 20%
Unusual Risk Characteristics	0 - 20%

Specialty Society Programs

Society Program	Dade	Broward	Palm Beach	ROS	Combine w/ Loss Free (Maximum)
FOGS (Florida Obstetric and Gynecologic Society) – Option A	5%	5%	5%	5%	Yes
FOGS (Florida Obstetric and Gynecologic Society) – Option B	5%	5%	5%	5%	Yes
FSTCS (Florida Society of Thoracic and Cardiovascular Surgeons)	5%	5%	5%	5%	Yes
FCACS (Florida Chapter, American College of Surgeons)	5%	5%	5%	5%	Yes
SFCACS (South Florida Chapter, American College of Surgeons)	5%	5%	5%	5%	Yes
Florida Chapter, ASIM-ACP	5%	5%	5%	5%	Yes
FOS (Florida Orthopaedic Society)	5%	5%	5%	5%	Yes
FCACC (Florida Chapter of American College of Cardiology)	5%	5%	5%	5%	Yes
BCSPRS (Broward County Society of Plastic and Reconstructive Surgeons)	N/A	5%	N/A	N/A	Yes
FSO (Florida Society of Ophthalmology)	5%	5%	5%	5%	Yes
Florida Association of Rural Health Clinics	5%	5%	5%	5%	Yes

Endorsed Programs

Endorsed Program	Dade	Broward	Palm Beach	ROS	Combine w/ Loss Free (Maximum)	Holder of Exclusive Marketing Rights
Sky Management	5%	5%	5%	N/A	Yes	PCC
Southeast Women's Healthcare – Option A	5%	5%	5%	5%	Yes NICA	PCC
Southeast Women's Healthcare – Option B	5%	5%	5%	5%	Yes NICA	PCC
Florida Chiropractice Medicine IPC	5%	5%	5%	5%	Yes	None
Urology Consultants	25%	25%	5%	5%	Yes	Gracey-Baker
VIVRA – Cardiology	5%	5%	5%	N/A	Yes	PCC
VIVRA – Orthopedic	5%	5%	5%	N/A	Yes	PCC
VIVRA – OB/GYN – Option 1	5%	5%	5%	5%	Yes NICA	PCC
VIVRA – OB/GYN – Option 2	5%	5%	5%	5%	Yes NICA	PCC
Endeavor Medical Group	5%	5%	5%	5%	Yes	None
Bradman Network – Psychiatrists	5%	5%	5%	5%	Yes	McCreary
Bradman – Psychologists	5%	5%	5%	5%	Yes	McCreary
Bradman – Psychotherapists	5%	5%	5%	5%	Yes	McCreary
FPA Medical Management – except OB/GYN	5%	5%	5%	5%	Yes	PCC
FPA Medical Management – OB/GYN – Option A	5%	5%	5%	5%	Yes NICA	PCC
FPA Medical Management – OB/GYN – Option B	5%	5%	5%	5%	Yes NICA	PCC
Urology Care Network	25%	25%	5%	5%	Yes	PCC
Physicians Health System (Charlotte IPA)	5%	5%	5%	5%	Yes	Marsh
GUT Management	5%	5%	5%	N/A	Yes	PCC
Prime Medical IPA	5%	5%	5%	5%	Yes	Marsh
Surgery Center of Stuart	5%	5%	5%	5%	Yes	Ostrom
NW Florida Surgery Center	N/A	N/A	N/A	5%	Yes	None

Exclusive marketing rights:

Only the agency that holds these rights may solicit physicians to join these programs. Solicit is defined as organized direct mail or telephone contact of physicians.

A physician who is a member of this program and is not represented by the exclusive agency is still eligible for the above discounts.